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Original Articles.

MEDICINE AS A PROFESSION.

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The young man of today in contemplating a professional career should consider seriously many points before deciding upon medicine. First of all he should fully realize the enormous amount of work ahead of him. The young man with a strong physical makeup and well balanced mind possesses a decided advantage over his weaker brother.

One should not arrive at a decision without first making a few observations. A consultation with some of his friends in the profession and a few visits to a hospital where he has the opportunity to see the different types of medical work will enable him to gain some idea of the duties of a physician.

The standardizing of the medical profession is in the hands of a well organized body of medical men, representing the highest type of men who have practically lived their lives in the medical profession and have stopped for a time to reflect upon its needs. They are influenced by nothing other than the good of the profession which means better trained and more skillful physicians to practice the profession.

If a young man questions his capacity for work and his ability to sustain the effort he should not think of entering upon the study of medicine.

The selection of a school is not of as much importance as is generally supposed so long as one selects one of the standard schools. The didactic work may be secured in any well conducted medical school. The practical training varies greatly. The smaller schools, properly located, train far better for the profession of medicine than the larger schools which are unable to properly handle the body of students as individuals.

From the time of entering the medical department until he ceases to practice medicine it is one continuous program of study and work. The physician who permits a year to go by without keeping abreast of the literature of that time cannot compare favorably his knowledge of medicine with the one who has not permitted this lapse of study.

One not in the practice of medicine has but little conception of the

amount of original work and scientific investigation being carried on in the many laboratories of the world. The latter term is not restricted to the immense structures which are comonly thought of when one speaks of laboratories. Some of the highest types of work are being done under adverse conditions, which only goes to show that individual mind rather than surroundings produces the result.

If one is in love with the study it is not a labor to carry on the work. No one should consider the profession for a minute who is not thoroughly in harmony with it. The law of Iowa today requires at least two years' work in a standard literary department of a college before entering a medical school. The value of this is very apparent to the observing teacher. The development resulting from the mental gymnastics gives the medical student of today a decided advantage over the student who a few years since was permitted to enter the department without even a high school training.

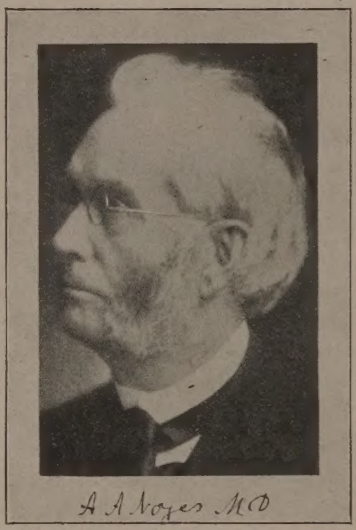
The work in the department from the Freshman year on through, while intensely interesting is not to be accomplished without the full quota of hours in study. The work is so correlated that the neglect of a single branch interferes with the knowledge of the subject, as does the dropping of a few propositions in higher mathematics in the consideration of that branch of study. The teaching is all directed in a manner to develop the thinking and reasoning powers of the student. It is not, as might be surmised, a mere matter of memorizing. In the medical schools the main lines of study have been outlined and the student comes along to the point where he must carry on the study consistently. If he is thoroughly in earnest and has been properly trained he will realize upon commencement day that he is just entering upon the serious study of a subject that will occupy the remainder of his life.

The successes and failures of physicians form an interesting study. Practically every physician should succeed if he is well qualified and has in mind the best interests of his profession. The financial return should be the last consideration. If he has done his work well, the patient is, with few exceptions, pleased to compensate him for his work. If he has treated the patient properly both in a scientific as well as a personal manner he need never fear the result. The most scientific and best trained man will not succeed in the practice if he is unfortunate enough to have acquired any habit that makes him disagreeable in the eyes of the patient. He should think enough of himself to care for his personal make up in a way that is above criticism. Many times he is present in the death chamber where no other than a man of the highest moral type should be. Many men fail because they fail to reach the proper standard of a gentleman. There was a time not many years since when a gentleman with but little knowledge of medicine met with

a fair degree of success, but the public today has become more discerning and is seeking the physician who is both well trained and a gentleman, one who must be trusted at all times and under all conditions. One of the first things for the young practitioner to learn is to be able to keep his professional secrets strictly to himself. The law protects him in this. I have known a number of physicians who were greatly handicapped because of their disposition to discuss their patients and their patients' ailments with others.

The practice of medicine has always been regarded as a noble work. To help an afflicted brother is appreciated not only by the brother, but also by those who have an opportunity to observe it. In some countries today the old custom obtains that the physician never makes a regular charge for his services. At certain seasons of the year his patients call and make donations. Considering this, one can readily understand a physician in such a community is not considering the remuneration, but merely that he is doing a good work and will receive his reward not in this world but in the hereafter. No young man, looking forward to the building up of a fortune, should consider medicine as a career. There are examples here and there of men who have made great financial successes, but the great majority merely secure a comfortable living. Of those who take up the study today, comparatively few drop the work. This is in a great measure due to the fact that the student first considers the requirements for entrance and then the vast amount of work necessary before he secures his license. It is much the same as the small investor, who hesitates but a few minutes, whereas, when a larger investment is considered, it is figured from every angle. A few years since when the practice was unregulated, anyone could take up the study for a few months and after a trial drop out and turn to another vocation. Today with at least six years required to complete the education, but few undertake it who have not fully determined to pursue it as a life work.

It is interesting to consider the position of the physician in the country village. He is always regarded as a man of superior attainments. His educational training should have carried with it the acquirement of a general knowledge which his fellow citizens many times call upon him to exercise. If he is right, intellectually, morally and as a gentleman, his influence in a very large measure directs the destines of his village. When his life's work is done there is more sincere regret in his departure than in that of the average citizen. He has lived among his people, has helped them in the hour of need, counseled with the leaders of the community and imposed upon no one. There should be none of the ill-feeling that is so apt to be associated with the dealings of the commercial man, following which many times a feeling is engendered never to be forgotten. The work of the physician is always for humanity and is therefore a noble work.



First Graduate of Keokuk Medical School, 1850
Now an Alumnus of Drake

"Born in Tunbridge Orange Conty, Vermont, November 25th 1828. From six years of age worked on a farm. Kicked and banged about until 1844. I voted for Henry Clay for President of the United States. Next day emigrated West. Commenced to read medicine and practice in 1846 Attended lectures three courses in Davenport Iowa and graduated from the first Medical College organized in Iowa, and from the first class ever graduated a student from said College in 1850. The oldest Practitioner in the U. S.

Dedicated to the Drake University at Des Moines Iowa this year 1911.

By the Photograph.

A A Noyes M D."

(Copy of original letter)

RHEUMATISM IN CHILDREN.*

F. M. FULLER, M. D., KEOKUK, IOWA.

Most physicians and all medical students feel pretty confident of their ability to diagnose rheumatism, either acute, articular or muscular.

With arthritis, pain, swelling, fever and lack of motion in mind, the condition is generally thought to be recognizable. Because all of these manifestations as seen in the adult are commonly absent in children; because many symptoms which are not seen in the adult are present as an indication of rheumatism in children; because many conditions are diagnosed rheumatism when they are not; and because so many children have rheumatism which is never diagnosed as such; I have concluded to present the result of a little study of rheumatism in children. It is a disease of vast importance. If we are going to be guided by our knowledge of the disease in the adult we will make many errors. Many diseases in children differ greatly from the same disease in the adult; none more so than rheumatisms. It is like dealing with another disease. We must know its multiple manifestations and recognize them, because over 50 per cent of all rheumatism in childhood is accompanied by heart lesions which may leave a patient crippled for life.

I have seen endocarditis of a severe form develop with tonsilitis, with torticollis, with obscure nonarthritis. When we are looking for a diagnosis we will seldom find that we were called on account of symptoms of rheumatism. We will not make our diagnosis from what is immediately present in the child. It will be necessary to get a complete and minute history of the child's life. With the whole picture before us we can then, and not till then, make a diagnosis.

We find an adult with sudden high temperature, hot inflamed tender joints, acid sweat, etc. A little care in excluding other causes of arthritis and we can reasonably diagnose rheumatism. We seldom see such a picture in a child. More properly we see rheumatism in a different frame.

The symptoms are frequently so slight or so masked as to be overlooked. They may be ascribed to other pathology. What we may think is rheumatism is often manifestation of another disease. We must get away from the idea of arthritis indicating rheumatism in childhood. Many children have severe rheumatic damage done with very little if any joint involvement. Many others who have distinct articular and peri-articular symptoms have no rheumatism. The special point that I have reiterated and which I want you to get is that,

*Read at First Annual Clinic of Drake Alumni Association, Des Moines, Iowa.

rheumatism is a disease which differs very materially in its clinical symptoms in childhood and adult life.

Some may say, what is the use of bothering about a little "growing pain" even if it is an evidence of rheumatism. Why consider seriously an array of symptoms which have not been severe enough to incapacitate the child and which are only recalled after careful questioning.

Why bother about a "touch of rheumatism" anyway. It don't last long, is never severe, the child seems well, and he will outgrow it. Sir Wm. Jenner well says, "Children don't outgrow rheumatism, it grows into them."

Baginsky says, "The distinguishing feature of acute articular rheumatism in children is the early and almost inevitable involvement of the heart." All except 7 of the 76 cases reported presented evidence of lively irritation or inflammation of the heart.

McConnell says it is surprising how many times one may find a heart murmur, if one is looking for it, with the history of growing pains or tonsilitis. It is this damage to the heart which is so common with all forms of rheumatism in children that makes it an important disease.

The most striking pathology, is an inflammatory endocarditis with or without fungus growths on the valves, and an exudative pericarditis with a tendency of the exudate to become fibrinous binding the pericardium to the heart muscle. No ill effects arise from these adhesions till the stress of puberty. Then we become familiar with the pale, anaemic, weakened, crippled boys and girls with their overlooked and neglected rheumatic hearts.

The Cause.

What is the cause of rheumatism? Is it the result of errors of diet? Is it caused by changes in tissue metabolism with the formation of toxins producing auto-intoxication? Is it due to an excess of lactic acid in the tissues? Is it or is it not a specific infectious disease caused by a definite micro-organism?

Is it caused by the common group of cocci, producing a modified pyaemia? I will not consider uric acid as a cause. The more recent knowledge of the chemistry of uric acid puts this agent out of consideration entirely.

The many theories have been persistently argued. That rheumatism is due to errors in diet or to too high a per cent of proteid diet cannot be maintained. Dr. Cook of the first Peary expedition reported that the most northern Esquimaux commonly suffered from rheumatism. They lived exclusively on meat in a cold climate.

Dr. Parks of the Stanley expedition in Africa found many cases

of rheumatism. These people lived chiefly on plantains and other vegetables in a torrid climate. The Japanese live in a temperate clime and eat chiefly rice. Yet rheumatism is a common disease with them.

In the literature I find many arguments in favor of the auto intoxication from food toxins or tissue toxins. I believe that there may be an auto intoxication but I do not believe it is the cause. We must have a well prepared soil as well as the proper seed. Auto intoxication if a factor, is only a predisposing cause. Gilbert and Lereboullet in their study of the "diathesis of autoinfection" note that many rheumatic patients get their infection thro' a digestive origin. Many suffer from billiousness. They state that acute articular rheumatism is in many cases the remote consequence of infection in the biliary tract.

As to lactic acid. An excess of this agent in the blood was held for years to be the cause of rheumatism. Prout and Foster in England were among the first to advance this theory about 1871. Foster claimed that two patients to whom he gave large doses of lactic acid developed polyarthritis. His experiments have never been satisfactorily repeated.

Prout claimed that under the influence of cold the lactic acid which is naturally formed in all muscular action was not properly oxidized, that it accumulated and the excess produced an irritation in the joints.

How he determined what an excess was I do not know for no one has ever yet developed a method for estimating the normal lactic acid content of the tissues.

An American humorist has said "It is not so much the ignorance of mankind that makes them ridiculous, as the knowing so many things that are not so." The general belief of all thoughtful medical men today is, I believe, that rheumatism *is* a general infectious disease.

The reasons for this belief are as follows:

It occurs in epidemics as well as in isolated cases.

The climatic conditions are constant.

Its onset is often of the same character as well known infections.

The blood conditions are similar to those in infections, low hemoglobin and leucocytosis.

The specific organism has not yet been isolated altho many competent students have reported their work ever since 1887. In 1897 Achalme found what he claimed was an organism which met all the required conditions but he later repudiated his own work. Tribault in 1898, Wasserman in 1899, both isolated a diplococcus in the blood, joints and heart of rheumatic cases.

In 1900 Payne and Poynton described a diplococcus which they called the "diplococcus rheumaticus" which had remarkable cultural peculiarities. Beaton and Walker investigated this organism more

thoroughly and found that it was present as a diplococcus in the tissues but became a streptococcus in bouillon.

A number of observers in different countries have obtained remarkably similar results in the bacteriological study of rheumatism.

The consensus of opinion now is that the specific organism has not been found. That the disease is caused by some form of the cocci, and that it may be a mild form of pyaemia with active toxins in the blood.

There are many contributory conditions. In considering these we must keep in mind the fact that they are not the cause of the disease. Cold and hereditary tendency no doubt helps to prepare the soil. Lowered vitality from any cause acts here as with all diseases.

The mode of infection is probably through the tonsils or the digestive tract.

Symptoms.

The symptomatology of rheumatism in children is what I wish to call your special attention to.

The types are several. There are many modifications of these types. In fact, most of the cases are atypical.

On account of this atypical course and the symptoms often being vague, the diagnosis is not easy.

Arthritis is not common. If present it may involve only a single joint. Redness and swelling are often not marked and may be absent. There may be only a sensitiveness or tenderness over the point involved. There may be a slight lameness or stiffness of the joint complained of on getting out of bed in the morning.

Fever may or may not be high. More often is not. It generally is of such a character as to be commonly ascribed to some other cause. "Growing pains" so-called, are almost invariably rheumatic. These must be carefully distinguished from muscle soreness from over exercise. This latter condition is always worse during the latter part of the day and is relieved by sleep, while "growing pains" are complained of generally in the morning.

Frequent nose bleed without apparent cause has been often observed in connection with obscure rheumatism. Frequent attacks of tonsilitis, are commonly seen with other rheumatic symptoms. A severe heart murmur may develop where tonsilitis is the only symptom.

If you will carefully investigate the family history of your cases of tonsilitis, you will often find the father or mother have had rheumatism. One or more of the other children have had mild chorea or rheumatism. You will almost invariably find a leaky heart somewhere in the family.

I don't mean that every case of tonsilitis is a symptom of rheumatism but I mean that many cases of rheumatism have tonsilitis as a constantly recurring symptom. Payne and Poynton have repeatedly

isolated from the tonsils a diplococcus which upon injection into rabbits has produced arthritis and endocarditis.

I recall one case, B. F. aet. 7, who was ill with tonsilitis, apparently simple follicular. The temperature rose the third day. I suspected involvement of the other tonsil. Examination showed the throat clearing. An examination of the heart revealed a distinct mitral regurgitant murmur. The boy was kept in bed. On the fifth day he complained of a severe pain in the right ankle joint. Salicylates promptly relieved the pain but the heart lesion of so recent development required rest in bed for three months. The diagnosis and treatment were concurred in by Dr. Babcock of Chicago. I could cite many cases in my own experience as well as a number in hospital observation where tonsilitis was the first and often the only precurser of a rheumatic heart lesion.

Torticollis where not due to a central nervous lesion is a common rheumatic symptom in children.

I have had a case within the past month where the first symptom was torticollis followed in a short time by a polyarthritis and fever. While there was no murmur the heart was decidedly irritable and I have no doubt whatever but that the boy will develop an endocarditis unless treatment is carefully adhered to. In this case both the mother and the boy suffer from recurrent tonsilitis.

Chorea is present as a symptom in quite a large number of rheumatic children. In the Vanderbilt clinic it occurred in 14½ per cent of the patients with rheumatism and of these cases of chorea (in which that was the first manifestation of rheumatism) 70 per cent had heart complications.

Dr. Lees in the meeting of the British Medical Association stated that while, in his experience, "Attacks of chorea are preceded by rheumatism less than once in three times, subsequent attacks of rheumatism occur in chorea patients, in considerably more than one-half of the cases; an attack of chorea being equivalent to an attack of rheumatism."

In fact Dr. Lees is inclined to consider chorea as a form of cerebral rheumatism.

Erythema is a common manifestation of rheumatism in children. I have two children in one family whose chief symptoms have been recurrent tonsilitis and erythema. One may be led at times in these cases to suspect scarlet fever but a little care excludes this.

Purpura is more common in children than in adults.

This array of apparently isolated and independent conditions will surprisingly arrange themselves into a group if you will carefully go over the history of your cases for one, two, three or possibly nine or ten years. Someone has well said that the history of a case of rheumatism is often the history of a whole childhood.

It is true, that we do find in children, especially from 10 to 13 the type of disease which is more like the adult, arthritis, fever, redness, swelling, immobility, etc.

It is also true that if you think that is the symptomatology of rheumatism in childhood generally, you will miss many a case. You will be called because of the tonsilitis, the chorea, the occasional slight pain or fever. If you fail of a thorough history you may treat the symptom and leave the disease go on through its insidious course for years till such damage is done the heart that neither you nor anyone can repair.

The first evidence that you may get is the cardiac. It grieves me to see the children just opening into adolescence who are brought to have relief from the distress of a broken compensation, when a history shows a continuous rheumatism covering a period of years.

The earlier rheumatism develops, the greater is the liability to heart involvement.

Remember the heart involvement is not a sequel nor a complication. It is a part of the disease, one of the symptoms. And this symptom is found, according to our most careful observers, in from ⅓ to ½ of all cases of rheumatism in children. You all know how enfeebling and shortening to human life is a heart lesion, especially one obtained in early life.

The careful study of this subject will lead one to a fuller appreciation of his responsibilities.

This is all the more true when we realize that it is the heart conditions which kill.

Prognosis.

The prognosis of rheumatism depends upon the improvement possible in hygienic conditions, the co-operation of the parents in the prolonged treatment necessary. So far as the rheumatism itself is concerned it is not often severe and seldom kills unless it affects the heart. It may go for years unrecognized and then leave a crippled heart for life.

In the diagnosis we must remember that every pain in a joint or even every arthritis is not rheumatic. Those conditions that are called "rheumatoid" are not rheumatic. Gonorrheal rheumatism is not rheumatism at all.

Arthritis deformans has nothing in common with rheumatism except both affect the joints. That disease is a curiosity among young children.

Diagnosis.

As I have said the diagnosis is often determined only by the family and carefully elicited personal history of the patient. The symptoms are eratic, separated, and often only suggestive.

With any of these indefinite symptoms present and with a temperature running a low course each day, with an irritable unstable heart with or without a murmur, after malaria and tuberculosis have been carefully excluded, your opinion can be with reasonable certainty laid upon endocarditis of rheumatic origin.

As to a differential diagnosis we must keep in mind that rheumatism is rare in infancy, but that we may have redness, great pain in the joints, fever and constitutional disturbance as symptoms of epiphysitis, especially of a syphilitic origin.

The pain of tubercular hip disease is almost invariably referred to the knee joint by the child.

Bone disease involving the spine and the long bones is very commonly first diagnosed as muscular rheumatism as the first pain complained of is referred to the muscles near the part. One of the first signs of Potts disease is pain in the abdominal muscles.

Treatment.

The treatment of rheumatism in children is in the first place prevention. In a family where rheumatism is found the children should so far as possible be kept under the best hygienic conditions. They should wear flannel the year round. Their diet should be so arranged as to give the best hemoglobin development and consequently the best nourishment. They should at intervals be examined for evidence of insidious symptoms. Diet has nothing to do with the case, except as it has an influence in maintaining nutrition.

The withholding of meat from a child of rheumatic history except during the acute attack, has no reason to commend it. The child is already anaemic and has need of proteid.

Children with repeated attacks of tonsilitis should have the tonsils carefully excised if for no other reason than as means of closing a port of entry, to many infections including rheumatism.

Cold feet should be avoided. On damp cold days with an east wind or with melting snow such children should be kept indoors or specially protected.

As to the treatment of the attack there are several things to consider. We must remember that rheumatism in children frequently does not show itself in a definite clinical picture. It must be treated over long periods of time. Where we have the symptoms pointing to rheumatic infection even though the manifestations are light, the child must be put to bed. By that I mean absolute rest. From mild attacks severe endocarditis may arise. Everything that will limit the number of joints involved, everything that will take effort off the heart, will lessen the tendency to heart involvement. Rest must be enjoined till all symptoms disappear, till fever is gone and till the heart does not become irregular on assuming the upright position.

Remember rheumatism is one of those diseases where one attack predisposes to another. Relapses increase danger of heart lesions. If the heart becomes affected there is no cure for it but months of absolute quiet. A few days in bed during even mild acute attacks may save weeks and months in bed and a bad heart. It is pretty hard to keep a child in bed who feels able to go skating but we are responsible for his future as well as his present. Diet during the febrile or acute stage is the same as during any other acute condition; easily assimilable food. Writers without exception agree on milk.

After the acute stage passes remember your disease as well as your medication tends to produce anaemia. Get your patients back on to digestible proteids as rapidly as digestion will permit.

Don't be afraid of meat in a rheumatic case. In the first place it don't increase uric acid in the tissues and in the second place, uric acid has nothing to do with rheumatism anyway.

As to medicinal treatment. Some swear by salicylates, some swear at them. Did it ever occur to you that the cases where salicylates did not relieve were not rheumatism? Many physicians diagnose every case of febrile arthritis as rheumatism and then when salicylates fail they blame the remedy. Arthritis may arise from many causes not rheumatic. I know of a case of multiple arthritis progressing badly under large doses of sodium salicylates. The physician was condemning the drug when the condition was a metastatic coccic infection from a wound on the foot.

The pain of real rheumatism is relieved by salicylic acid or the salicylates. To children it should be given in full doses. If followed by milk it will cause little if any gastric disturbance. The English give larger doses than we do. I have seen in the Hospital for Sick Children in London, a grain for every pound of the child's weight given every 24 hours. This was usually given with an equal or almost equal amount of sodium or potassium bicarbonate.

I find it more satisfactory to give a pure salicylate (made from wintergreen, not from coal tar) till all symptoms of fever and pain disappear. Then reduce the salicylate and give the potassium bicarbonate in 5 to 6 grain doses every 3 to 4 hours.

The pain and swelling can often be relieved by local applications. Cloths wrung out in hot solutions of sodium bicarbonate covered with oil silk and flannel and changed when cool, give relief. Ol. Gaultheria. Ichthyol and Lanoline applied as an ointment will often allay pain.

Slight stiffness and pain is often relieved by splinting, especially so in younger children. The important point in the treatment of rheumatism in children is the necessity for persistence. It will not do to be satisfied with relieving the several attacks. The attacks must be pre-

vented if possible. This can be well accomplished by continuing treatment with salicylates over months of time. The best method is to give 3 to 5 grains 3 times a day, every alternate week for 6 to 12 months.

For the heart involvement, absolute rest is essential. Some cases can be cured if taken in time and kept under control. I have records of several such cases. R. Caton of Liverpool uses small blisters over both sides of the chest from clavicle to nipples. He gives good records of recovery.

The subsidiary treatment is the administration of iron to relieve the anemia. Where there has been much exudation the iodides must not be forgotten as absorbents.

I have also used mercuric chloride in small doses with good effect. It is assumed that throughout the whole treatment elimination from every source must be encouraged, keeping in mind, however, that too free elimination increases anaemia. This paper is already too long, but I have been led to a full consideration of all phases of the subject because I consider rheumatism in children a serious disease. More serious because its damage is mortal and is accomplished so insidiously. It is serious because we so frequently see the condition overlooked by physicians and because a misconception leads us to diagnose rheumatism when it is not present. It occurs more commonly in young children than we realize, because what we see doesn't look at all like rheumatism.

In this paper I have not attempted to divide the condition into acute, sub-acute and chronic. While we do see typical rheumatism in children, yet my object in writing this paper is to impress upon your minds more fully the frequency with which the disease appears in its atypical form.

Not all forms of heart disease by any means are due to rheumatism in children, but many are, and those that are can be in some degree prevented by a more careful watching of those indefinite symptoms which arise in the children who in the course of our work are placed within our responsibility.

HIS FOND HOPE.

Little William, son of an automobile enthusiast, lost a tooth in a fall from his sled.

His mother told him that she would have to take him to the dentist immediately to have it replaced.

"Oh, no, Mother," said Willie; "Let's wait till spring. Maybe Dr. Guy will have a new model ready for us by that time."

Exchange.

DIAGNOSIS OF SURGICAL URINARY DISEASE.

BEN C. EVERALL, M. D., WATERLOO, IOWA.

The art of healing is now more nearly an exact science and less of an art than ever before, yet the two great divisions of healing; namely, internal medicine and surgery, have not been equally progressive; surgery because of the tremendous possibilities, opened to it comparatively recently by the practice of ausepsis, is a younger science, while internal medicine, because of its age, journeys slowly, as befits its more mature stature. Surgery, however, dates its real birth from Lord Lister's teachings, because true surgery is measured only by the application of all of its principles; and with the impetus gained from ausepticism, we find a corresponding increase in the attention given surgery and also in the remunerative possibilities of this branch, to the extent that the field of surgery becomes the battle ground of the brightest intellects, and the most agressive personalities, so that it is no wonder that internal medicine has been in some degree slighted. In some branches of surgery, we find greater progress than in others. The reason for this unequal development, lying, I believe, in the varying difficulty of attaining an exact diagnosis of the different surgical regions. In one branch, at least, has progress been noticeably slow; that is, in the surgery of the urinary system with special reference to the kidney, ureter and bladder.

Blind surgery of the kidney is especially fraught with dangers, which are so well known that mention alone is scarcely necessary, yet with these dangers so well known, will you believe my assertion that blind surgery of the kidney and ureter is still the rule? Will you believe that in this age of cystoscope, the ureteral catheter and refined urinary analysis and all the various data at our command, it is estimated that nine out of ten kidneys are cut down upon without knowing the functional capacity of the opposite kidney, indeed, without knowing if there be another kidney. Prostates are removed by the perineal route with large stones in the bladder, which necessitates tremendous laceration and trauma of delicate organs, when one glance through the cystoscope, would save suffering, loss of function, and perhaps life.

Indicating then sufficient reason for caution in all surgery, and more particularly in surgery where a misstep means death, I must insist that in this day and age, performing any manner of operation on any organ or region without using all the information obtainable, is, to put it mildly, careless. In the case of the kidney, to operate except in rare instances, without using a cystoscope and other methods, may not only be careless, but criminally so.

I shall in this very limited paper point out or emphasize some of

the procedures by which any physician or surgeon may secure a reasonably sure diagnosis providing ordinary care and judgment is used. No detail of technique can be attempted at this time, my purpose being more to emphasize the desirability of making use of easy means to important ends, than to attempt to instruct in any special method.

I shall take up diagnosis of the kidney and ureteral diseases largely from a cystoscopic standpoint and limit myself almost entirely to this side of urinary diagnosis. It is presumed that we all have in mind the usual clinical signs and tests, but have neglected to make use of the cystoscope and ureteral catheter. The slight experience I have had with these instruments was acquired during my service with Dr. Wm. Braasch of Rochester, Minnesota, and to him I extend the credit for the most of my remarks. The instrument I use is a Braasch cystoscope, which I believe is better fitted than any other for the occasional cystoscopist being simple in construction and easy of manipulation, and as all other cystoscopes are a modification of the Elsner type of scope.

Rapidly I will sketch the procedure of an ordinary cystoscopy. Given a case with pathological urine with or without pain (pain as a whole being the most unreliable of all symptoms in urinary diagnosis). To illustrate—Patient A has great pain, tenderness, and palpable right kidney with urinary pus and blood. (Plain case of kidney derangement.) Incision made, large engorged right kidney exposed and incised. No pus or path found. Urinary suppression and death followed. Post mortem disclosed dead T. B. kidney, on the left side. Compensatory hypertrophy of the right kidney, caused the pain in the right kidney region.

Nevertheless pain with corroborative evidence such as pathological urine should call for investigation. After the introduction of the cystoscope into the bladder, we examine this organ as a whole. Neoplasms, calculi, ulcerations, trabeculae and diverticulae are at once noticeable if present. Next, the ureteral orifices are seen. May be normal inflamed, pouting, gaping, pendulous, etc. A red pouting meatus with the other side normal, pus in the urine and mild cystitis is almost pathognomic of T. B. kidney; even if no T. B. are found. At the meatus, stones occasionally project. Next, observe ureteral paristalsis and urinary spurt. Clear glycerine-like discharge is nearly always O. K. If cloudy, suspect pus and triple phosphates or both, and by the way pus means but one thing, and that, that something is radically wrong, but is typical of nothing. Being found in pyelitis, abscess, stone, hydronephrosis and malignancy, and next to pain the poorest symptom by which to make an exact diagnosis.

Blood from one ureter means stone, T. B., neoplasm, or essential hematuria; the latter is by no means uncommon. I have seen six cured

by simple incision and replacing after lock-stitching the kidney incision. Profuse hemorrhage points more strongly to malignancy than otherwise, in the hypernaphromata, the urine is nearly black, due to degenerated blood pigmant, and is very typical. Here it is well to state that tumors, malignant or benign of upper pole of the kidney cause earlier and more acute symptoms and urinary derangement; hence, earlier diagnosis, and more often a cure is obtained, while the reverse is true, the further from the upper pole and pelvis. Before proceeding further, we inject one grain of indigo-carmine under the skin of the patient. If no color shows from either ureter from twelve to fifteen minutes, we doubt the functional integrity of both kidneys. If one is delayed only, we again assume that one kidney is more or less deranged in proportion relatively as the time it takes to show color.

Our ureteral catheter is now called upon at this point. Selecting the meatus showing the pathology, we insert catheter. Obstructions are of two kinds; surgical and non-surgical. Non-surgical inflammations are those which will subside. Congenital narrowing and spasm are non-surgical. Surgical obstructions are stones, tuberculosis, trauma, pressure from the outside, angulation caused from pressure from the outside, anomalous blood vessels. The catheter may pass obstructions. Stone causes a typical sensation of scratching felt by the fingers, and with Howard Kelley's waxed catheter may show marks. Steady, gripping, means usually structural derangement or angles. No entrance to pelvis is assumed if less than 27 C. C. of catheder are admitted, 30 to 40 being normal, average 34. Over 50 C. C. indicates enlarged pelvis as in hydronephrosis. If 50 C. C. are admitted and hydronephrosis is suspected, we are strengthened in this belief if the spurt of urine from the meatus was weak. Next, in hydronephrosis we meet slight obstruction at the uretero-pelvic junction, which is overcome by slight pressure. This obstruction is caused by angulation. Last, the injection of over 40 C. C. without causing an artificial Kidney colic. We used colored fluid because if the return fluid escapes, the test is of no value. Pain in hydronephrosis is intermittent or chronic, often absent. If present, is clinically much like calculi but less acute, less blood, less radiation; all may be present and in general the same. Collargol injected into the pelvis gives exact evidence when radiographed as to pelvic outline and if previous radiograph showed stone, and the outline is lost in the collargol radiograph, we assume the stone to be in the pelvis of the kidney. If separated from the pelvic collargol shadow and still within the kidney shadow, cortical stone is inferred, but it is to be remembered that dense gall stones and calcarious glands and phleboliths, give shadows. If less fluid than 5 C. C. is tolerated, hypersensitiveness of pelvis or pelvic

encroachment is suspected. Hypersensitiveness of the pelvis is found in neurosis and in pyelitis; encroachment is by stones, neoplasms or from extraneous pressure. In tumors, your collargol may again help as nearly all neoplasms cause distortion of pelvis, especially hypernephroma. Before I forget, I wish to call attention to the colic caused by artificial distention of pelvis. If like pain previously complained of at the site of the injection and referred to the same points, we suspect this point to be pathological. If the pain is of a different nature than of the one complained of, in most cases we may rule out the kidneys, but this is not by any means reliable.

In regard to treatment little will be said. The diagnosis suggests the treatment. The principles involved are few in urinary disease. If sufficient kidney is left to be of value and free natural drainage is obtained, plastic work on the kidneys gives good results. There are few benign neoplasms of the kidney, and malignancy is strongly suspected in any new growth about the kidney. Cystic kidneys are often dead, and should be removed if conpensation seems possible. Malignancy as elsewhere demands early and radical removal, and is rarely curable because of the rapid metastases and early extension. Hypernephroma, that strange malignancy of the kidney, is seldom, if ever, permanently cured, in spite of the fact that good health may be enjoyed in six months to six years when removed. In pus, drain or remove the cause. As suggested before, hemorrhage is often cured by simple incision, even if the exact point of bleeding is never discovered. There is no more palliation possible in T. B. kidney than in malignancy and none should be attempted. Remove the entire kidney, or nothing. Decapsulation is valuable in selected cases. Surgical treatment of the ureter and bladder requires common surgical judgment and a good technique. In all surgical diseases of the urinary tract, drugs are of very little value except urotropin, which I recommend in full doses before and after operation combined with equal parts of soda benzoate to avoid irritation.

DRAKE MEDICAL SCHOOL

SOME PAST HISTORY OF DRAKE MEDICAL ALUMNI ASSOCIATION.

CHAS. F. SMITH, M. D., DES MOINES, IOWA.

On the character, ability and energy of the alumni of any institution depends the standing of that institution with the general public, and the reputation of an institution is as important to success of an institution as it is to an individual. Ours is the day of specialties, and organization in all lines of business enterprise, and it is as important educationally as in mercantile lines.

The most important medium of organization and development in Colleges is through the alumni, and through the alumni as an organized active body, only can come the best results.

In 1897, the graduating class of the Medical Department of Drake, saw the need of co-operation and activity, and accordingly organized the first Medical Alumni Association of Drake, with Dr. D. S. Fairchilds, Jr. of Clinton, as President, and Dr. W. S. Conkling as Secretary.

Everything looked bright for the organization when the Spanish-American war broke out, and our able officiary was called to serve its country in the Phillipine Islands. Both quickly merited and received promotion, and at the close of the war returned to their professional duties with honor.

In the absence of the officers, there was no activity in the Association. It remained dormant until the spring of 1905, when Dr. E. R. Limbocker, then a senior medical student, recognized the great need of revival of the organization, and went about it untiringly, and his efforts were amply rewarded, and the organization has steadily grown and prospered, and in the year 1910, it was decided to attempt a three days' session, consisting of clinics, dissections and demonstrations. This, we believe, was voted a great success by all who attended, and all felt well paid for the time and expense incident to attendance.

Too much credit cannot be given the able Secretary-Treasurer Dr. E. B. Mountain, who worked untiringly throughout the year and was justly rewarded by unanimous re-election; and with the able President, Dr. W. S. Conkling, the work of the year 1912 is progressing rapidly, and the success for the clinic next spring promises to far surpass that of this year.

It was with a feeling of great satisfaction to most of us who have been out of school for a few years, to return and see the great advancement in facilities, the equipment and the teaching staff of the Medical College.

This progress has been an inspiration to those of us who were so fortunate as to attend, and we feel we should urge upon all the grad-

uates of Keokuk and Drake Medical, to identify themselves with this active body of progressive professional men, who are striving to make the Drake Medical College one of the centers of medical education in the West.

It is certainly gratifying to know that half the membership of the alumni association is now made up of the graduates of the Keokuk Medical and the officers of the association feel gratified and honored to have them getting actively into the work.

The Drake graduates wish all to know that the Keokuk graduates are as welcome as the Drake men, and we need every alumnus of both schools, and we hope to make each one who attends the clinics and meetings feel that he can not afford to be unidentified with the association, and we extend a most cordial welcome to come in with us now.

We can't help judgin' fellers by what the poets call their environment. Take the skunk, fer instance. It ain't the skunk so much ez the atmosphere in which he lives thet's responsible for his bad reppytation.

JOHN KENDRICK BANGS *in July Lippincott's.*

METHODIST HOSPITAL

THE PHYSICIAN AS A CITIZEN.

THOS. F. DUHIGG, M. D., DES MOINES, IOWA.

The contributions to human progress made by physicians, aside from those that were strictly professional, have been great in every age. It seems peculiarly appropriate that men with the education, practical experience and optomism of physicians, should have great influence in what is popularly known as the larger affairs of men. The activities of educated and scientific men will never be too great in the settlement of vital questions. Indeed we should encourage this class of citizens to give more of their time and energy to the practical side of life. This will be beneficial to society as well as to have a broadening and educational effect upon physicians themselves.

One cannot know but one book and know that well. General education must precede special education. All education is linked and interwoven. It is all valuable. Education in any department of art or science or history can be made useful to one no matter how high or mediocre his position in life may be. The subject of medicine is as broad as humanity itself. It is so broad in fact, and its successful practice involves the correct application of such an array of scientific principles and such exact reasoning that one may confine himself entirely to the practice of medicine and still be broad. However, those outside of the profession will not appreciate our breadth unless and until we demonstrate it in some practical and easily comprehensible manner.

If the physician will apply his excellent knowledge to the solution of practical problems of politics and sociology, there is every reason to believe that he will have greater success in proportion to his greater experience and better training. He should study the other questions of life with the same system and tenacity that he masters a difficult clinical test or a tedious surgical technic. They should be studied diligently either as a serious undertaking or as a diversion or hobby.

Oliver Goldsmith, one of the great masters of literature began his literary career by utilizing his unoccupied time as a young practitioner of medicine. His "Vicar of Wakefield," "The Traveler," and "She Stoops to Conquer," have established him as a literary genius. The study of medicine taught him to think.

Copernicus discovered the greatest single astronomical truth that has ever been revealed, viz., that the sun is the center of our planetary system, around which all other planets move. Besides practicing medicine among the poor, he established the great fact that the sun is the hub of the universe.

Bichat in his "Physiological Considerations on Life and Death" advanced the subject of biology by greater bounds than it had made since the time of Aristotle.

Lamarck, in addition to the study of medicine became the founder of invertebrate zoology.

While professor of medicine at Basle, Bernoulli published his "Hydrodynamique," which was a treatise on the motion of fluids. His explanation of the cause of tides and his theory of oscillation and its application to the wave-theory was of great importance in different branches of physics.

Galileo, the author of the law of falling bodies, and Alexander Hamilton, the great master of finance and first secretary of the treasury both studied medicine.

Oliver Wendell Holmes probably did as great a service to humanity by publishing his "Autocrat of the Breakfast Table," "Elsie Venner" and "The Wonderful One Hoss Shay," as by his experiments in physiology and chemistry.

S. Wier Mitchell, in addition to being one of the great physicians of all time, has found time to write "Hugh Wynne" and "The Adventures of Francois," besides several volumes of fiction and poetry.

Dr. Sun Yat Sen by orderly, deliberate and persistent effort has brought about one of the greatest revolutions that has ever taken place. Two years ago if one were to make a prediction of something which was the least likely to happen, he might have suggested a republic in China. Yet today it is an accomplished fact, with every department essential to self government including a national debt. The Republic of China representing 400,000,000 of people is the greatest experiment in self government that has ever been undertaken upon this earth.

There were 22 physicians in the first Provincial Congress of Mass. in 1774-1775.

The following named physicians were signers of the Declaration of Independence: Joshua Bartlett and Matthew Thornton of New Hampshire; Oliver Walcot of Conn.; Benjamin Rush of Pa., and Lyman Hall of Ga.

Dr. Joseph Warren was the first to fall in the battle of Bunker Hill while fighting as a soldier.

Dr. Hugh Mercer was a Brig. General in the Revolutionary War.

Dr. Hugh Williamson was congressman from North Carolina and author of a history of that state.

David Ramsey of South Carolina was a surgeon of militia in the Revolutionary War; state legislator; member of Congress; speaker of the National Home of Representatives; author of the History of the Revolution in South Carolina and later his famous History of the American Revolution.

Dr. Nathaniel Alexander of North Carolina, Dr. Lyman Hall and Dr. Bromson of Ga. and Oliver Walcot of Conn., were governors of their respective states.

Benjamin Rush was a signer of the Declaration of Independence and a member of Congress.

In the older countries physicians are often rewarded with public office for excellence in their chosen profession. The greatest among them in their mature and advanced years are elevated to positions of public trust. In this country, by some paradoxical method of reasoning, physicians are supposed to know nothing but medicine. And the better the physician, it is assumed the less he knows about everything else. It is your duty and mine to correct this distorted notion. This can be done, not by holding aloof to avoid criticism that follows participation in the adjustment of public questions, but by assisting in their solution and by meeting criticism as we do in other lines.

At the present time about 11 per cent of the Italian Parliament is composed of physicians. About 10 per cent of the French Senate are physicians. Crosby, the great English surgeon is the present Lord Mayor of London.

History is filled with great accomplishments that have been wrought by physicians. For those of us who care to indulge in outside activities, we have some of the brightest lights of history for our example and inspiration. Every department of knowledge has been enriched and every phase of human activity has been influenced by the members of our profession.

MERCY HOSPITAL

J. C. HUGHES, M. D.
Pres. of Keokuk Medical College
From 1853 to 1882

GEO. F. JENKINS, M. D.
Pres. of Keokuk Medical College
From 1900 to 1908

FORMER DEANS

LEWIS SCHOOLER, M. D.
Dean of Drake Medical College
From 1888 to 1903

D. S. FAIRCHILD, M. D.
Dean of Drake Medical College
From 1903 to 1909

E MEDICAL COLLEGE

Dr. Walter L. Bierring's Medical Clinic at Methodist Hospital April 17, 18, 1912.

On the first day the following cases were presented:

No. 1. Progressive pernicious anaemia:

Patient was a man 44 years of age, a farmer by occupation, of previous good health; duration of present illness eight months. The blood findings were as follows: Hemoglobin 20 per cent, red cells 900,000, leucocytes 2,600. Stained spreads revealed marked changes in the red cells as to form, size, and of very large cells, abnormal staining; a few normoblasts were present. Differential count of the leucocytes revealed—polymorphonuclears 55 per cent, large mononuclears 20 per cent, lymphocytes 21 per cent, eosinophiles 1 per cent, basophiles 3 per cent.

The gastric contents showed an absence of free hydrochloric acid, a very low degree of milk curdling ferment. A moderate diarrhoea was present.

Paresthesia, hypersthesia, pallasthesia of the lower extremities are present.

The clinical discussion referred principally to the differential diagnosis from gastric carcinoma, and the different methods of treatment for this condition, among which special reference was made to the glycerine treatment which has offered some promising results. The dose of glycerine is a half drachm three times daily, which is gradually increased to the point of tolerance, the maximum dose being about a tablespoonful.

No. 2. Chronic myelocytic leukaemia:

Patient was a man 38 years of age, a commercial salesman, who has been under observation for a period of three years, during which time he had undergone a number of unusual remissions of improvement. The most remarkable of these had been experienced during the past year, the change for the better being brought about by passing through a severe local and systemic septic infection, produced by a large carbuncle of the back. The blood examination preceding the pyogenic infection revealed—hemoglobin 60 per cent, red cells 4,410,000, leucocytes 370,000. Differential count—polymorphonuclears 42 per cent, large mononuclears 1 per cent, lymphocytes 2 per cent, eosinophiles 1 per cent, basophiles 1 per cent, myelocytes 53 per cent.

Six weeks following this blood examination, and after the carbuncle and systemic infection had subsided the following blood condition was noted. Hemoglobin 80 per cent, red cells 4,120,000, leucocytes 28,800. Differential count-polymorphonuclears 91 per cent,

lymphocytes 7 per cent, myelocytes 2 per cent, which indicated a distinct difference in the character of the blood, and illustrating the antagonism that appears to exist between pyogenic infections and leukaemic processes.

The patient passed from observation soon after the recovery from the septic infection, but he recently returned after an absence of two months. Soon after his re-admission to the hospital, March 19th, he was given gradually increasing doses of vaccines, prepared at the Pathological Department, of staphylococcus pyogenous, and again a marked change for the better is being noted in the patient's blood condition. The present blood findings are as follows: hemoglobin 70 per cent, red cells 3,850,000, leucocytes 29,600. Differential count—polymorphonuclears 66½ per cent, myelocytes 14 per cent, lymphocytes 6 per cent, large mononuclears 4 per cent, mast cells 7½ per cent, eosinophiles 1 per cent. A few nucleated red cells are present.

It is interesting to note that the size of the spleen has been reduced whenever an improvement took place in the blood condition.

No. 3. Hyperthyroidism, incomplete exophthalmic goitre.

Young woman, 28 years of age, married. During the past eight months has gradually developed symptoms of hyperthyroidism in the form of goitre, tachycardia, and tremor, but exophthalmus is not present. Condition of hyperthyroidism is apparently associated with the development of an acute salpingitis for which the patient was referred to the hospital for operation. In view of this rather unusual relationship, the patient is referred to the gynecological service for the treatment of her pelvic condition.

No. 4. General visceroptosis, Glenard's disease, malnutrition, chronic entero-stenosis.

Woman 46 years of age, single, chronic digestive disturbance covering a period of six years, with gradual loss of weight. At the present examination a marked hypostasis of the abdominal muscles is noted, and an unusual ptosis of all the abdominal viscera, the low position of the stomach and transverse colon being especially emphasized by a Roentgen photograph. A very marked visible peristalsis of the bowel with accompanying obstinate constipation and occasional colicky pains suggests the entero-stenosis, which is often the terminal stage of Glenard's disease.

No. 5. Chronic hypertrophic pulmonary emphysema, arteriosclerosis, dilation of the aorta.

The patient is a man 55 years of age, a coal miner by occupation. Presents the three cardinal symptoms of chronic emphysema; dyspnoea, bronchitis, and cyanosis, the latter being present only to a moderate degree. He presented furthermore all the physical characteristics

of an emphyzematous chest, the heart's area of dullness being completely obscured by the emphyzematous lungs. In order to determine the size of the heart an X-ray examination was made, and the resulting radiograph revealed a marked dilatation of the ascending portion of the aorta, which at first was very suggestive of an aneurysm. In view of associated arteriosclerosis which is present in this case, it is quite likely that a dilatation of the aorta is present, but in making a large number of radiographic examinations of the heart and connecting large vessels, we have often been confused by the sharp curve which the aorta makes toward the left as it passes upward and backward, and which unless correctly interpreted may easily lead to a diagnosis of dilated aorta or beginning aneurysm.

On the second day the following cases were presented.

No. 1. Chronic infectious endocarditis, exophthalmic goitre, embolic occlusion of right popiteal artery resulting in ischaemic gangrene of the right foot and leg.

Patient was a young man 23 years of age, cook by occupation. Three years before admission into the hospital he passed through a severe attack of acute rheumatism, which resulted in a chronic valvular lesion in both the mitral and aortic valves. Within the past year and a half, symptoms of hyperthyroidism have developed, and at present the clinical picture of an exophthalmic goitre is present in his case. Three weeks ago following an attack of acute influenza, a severe pain developed in the right foot and leg, which at first was thought to be a recurrent attack of acute rheumatism, but was soon followed by a discoloration of the big toe, moderate oedema of the leg, and at present a distinct gangrene of the foot and lower third of the leg is present. The pain in the affected limb has been exceedingly severe, and is modified only by very large doses of morphine. The patient was referred to the surgical service of Dr. Fay, who later in the day amputated the limb in the upper third of the leg.

This case illustrates the tendency of an infectious endocarditis to develop during the course of an acute infection when chronic valvular disease exists, and also clearly demonstrates the relationship between endocarditis and peripheral embolism.

No. 2. Acute parenchymatous nephritis, general oedema, uraemia, thrombosis of the right lateral and cavernous sinus.

Patient a young man 21 years of age, Austrian immigrant, who on his arrival in New York about February 22nd developed a severe attack of tonsilitis, which resulted in an acute nephritis for which he was referred to the hospital about two weeks previous to this examination. He presented an unusual picture of general subcutaneous oedema. Free fluid in both pleural sacs and in the peritoneal cavity. The urine

is very scanty in amount, highly albuminous, and the sediment consists almost entirely of granular cells, hyaline and granular casts. The tongue is very dry, the patient was apathetic, and frequently delirious. During the past forty-eight hours an unusual prominence of the right eye has developed with an infiltrative swelling of the entire right side of the neck. When referred to the ophthalmologist, Dr. Werts, this was recognized as a clear indication of thrombosis of the lateral and cavernous sinus. Involvement of either of the mastoids does not seem to be present. (The patient succumbed to his illness three days following this clinic, and the autopsy corroborated the clinical diagnosis.)

No. 3. Chronic interstitial nephritis, hypertension, cardiac hypertrophy, disturbed circulatory compensation, oedema of the lower extremities.

The patient is a man 54 years of age, laborer, has been a periodical heavy user of alcohol. Has not suffered any special discomfort from present illness until the last year, during which times has had periodic attacks of headache, mild digestive disturbance, dyspnoea upon exertion, and has been admitted to the hospital on two occasions on account of marked oedema of the lower extremities. At the present examination the systolic pressure is 220, and hypertrophy of left ventricle exists to a marked degree; the subcutaneous oedema is present in both lower extremities. Numerous moist rales are heard over the lower lobe of both lungs. Th urine contains albumen 1-10 per cent by Esbach, with numerous hyaline and granular casts in the sediment. Patient is receiving elaterium 1-8 gr., every six hours, 1 drop of 1 per cent solution of nitro-glycerine every three hours, hot brick sweats every day. The diet permitted includes milk, cream, eggs and vegetables.

The condition is improving and the circulatory balance will evidently be again re-established.

No. 4. Mitral stenosis and insufficiency. Hypertrophy of heart involving left auricle and ventricle and right ventricle. Moderate compensatory disturbance.

Patient is a young man 26 years of age, laborer, giving a history of two attacks of acute rheumatism during the past six years. During the past year has been troubled with occasional dyspnoea, short attacks of bronchitis, and some oedema of lower extremities.

Physical examination reveals the characteristic changes of a combined mitral lesion, a very marked palpable presystolic thrill being present. A radiograph reveals a large round heart figure such as is noted particularly in combined valvular lesions with beginning compensatory disturbances. Patient was admitted to hospital two weeks ago, and under the influence of rest, depleting measures and digitalis,

is gradually improving with the prospect of having his compensation re-established.

No. 5. Congenital lues; interstitial hepatitis, moderate ascites, severe pernicious anaemia. Severe and fatal epistaxis.

The patient was a child fifteen months of age, that had just been admitted to the hospital. It was difficult to obtain an intelligent history in regard to the health of the parents, and in regard to the child's previous condition it was learned that it had never been a strong child, having a great deal of digestive disturbance during the first six months of its life. At eleven months of age a gradual pallor developed, and lump appeared in the upper abdomen. When first seen by a physician three months ago, the enlargement in the abdomen was found to be a greatly enlarged liver, which still exists at this examination, and fills the entire right hypochondriac region, the lower border being palpable below the umbilical line.

At present there also exists a moderate degree of ascites, some icterus, and a very profound anaemia. The blood examination reveals the following: haemoglobin 30 per cent, red cells 1,800,000, white cells 2,200. During the past two days a severe nose bleed has developed which is difficult to control, and on that account the patient was referred to the hospital.

In considering the treatment for the hemorrhage it was decided to give the child 10 cubic centimeters of human blood subcutaneously in addition to local stiptic measures. The child was in a very weak condition when brought to the hospital, and lived only a few hours after admission, the death occurring early in the afternoon of the day that the case was demonstrated at clinic. While the time did not permit having a Wasserman test made, the general symptoms and particularly the presence of the large liver was very suggestive of hereditary lues.

An autopsy was not permitted.

Dr. F. A. Ely's Neurological Clinic at the Methodist Hospital, April 18, 1912.

It is not my purpose this morning, to present a number of unusual cases, but rather to bring before you three or four patients suffering from nervous affections, from whose symptoms you may learn a few valuable clinical points which may help you in your work as general practitioners.

In order that we may not overstep the time allotted to us for this clinic, we will not take up the histories of these cases in detail, nor shall we dwell upon all of the symptoms which they present, but will confine ourselves to the striking features which are most apt to be overlooked or misunderstood.

The first patient who is now before you, is a male of Swedish

descent, aged forty-five, who for the greater part of his life, has been a laborer. Some fifteen years ago, he contracted Lues, for which he was treated for about six months in an indifferent manner. About three years ago he developed an oedematous swelling of the left knee, which was treated for rheumatism, and in this case, according to the history given, this mistaken diagnosis was not so much to be criticized, because of the fact that the joint was more or less painful. The swelling receded in a few weeks and the function of the knee was fully restored. About this time he began to suffer from shooting pains in his lower extremities, slight inco-ordination in walking and transient sphincter weakness. About twelve months subsequent to the first articular trouble, his knee again became swollen and as before, after a few weeks resumed a normal appearance, with the exception however, that th joint seemed more loose and relaxed than normal. A few months later the knee became swollen for the third time, and after that never returned to its normal size but increased in thickness until it has assumed the swollen, irregular and gnarled appearance manifest at the present time.

In making a hasty examination of this patient, we will observe that the pupils are small and immobile to light; the tendon reflexes of the lower extremities are lost; co-ordination in all four extremities is very much impaired; and in addition, there is a marked paretic weakness especially in the lower extremities. As you will all agree, then, we have before us a typical case of Tabes in the paralytic stage, and were it not for the presence of this well developed Charcot joint, I would not take up your time in the demonstration of the case.

To him who is not immediately in touch with free dispensaries and city practice among the poorer classes, a Charcot joint is not common, and yet even the moral tiller of the soil is not exempt from Lues, and where Lues is, there is Tabes also; for Tabes is Lues in a modified form, and any Tabetic is apt to develop a Charcot joint. Therefore it is well for even the country practitioner to be on his guard lest he mistake a Charcot joint for some other type of Arthritic difficulty. The writer himself knows of at least six instances in which extensive surgical measures, including amputations have been instituted in cases of this kind.

The Tabetic joint has features all its own whereby it may be diagnosed with comparative ease, even without observation of the other symptoms of Tabes.

In the first place, a Charcot joint is usually painless, both subjectively and upon manipulation, as is this knee at the present time.

In the second place, this type of arthropathy usually presents a

marked relaxation of ligaments; it often being possible to produce a complete painless dislocation by slight manipulation.

In the third place, you can usually demonstrate a degree and quality of crepitus, which when once felt, is seldom forgotten.

In order that we may the better demonstrate this relaxed condition of the joints, which is not confined alone to those which are enlarged, I will proceed to place this patient's heels behind his head, a feat which few normal men of forty-five or over, would be able to accomplish. You will observe that this jack-knife position causes the patient no inconvenience whatever. I shall always bear in mind a tabetic who was on my service in the Clarinda State Hospital, who from choice slept with his thighs and legs extended, and his abdomen flexed upon his thighs.

If a few of you will examine this knee, you will be struck by the free movement which is possible between the articular surfaces. You will also observe that several of the exostoses have been broken off, and upon palpation, you will detect the "Bag of Bones" feeling, which should always speak for a Charcot joint.

It will be rememebred that in stating the early history of this affected knee, it was mentioned that the joint was painful. Now this may be accounted for in one of two ways: (a) Either the shooting pains of Tabes were anatomically or mentally referred to the joint, or (b) The sensory symptoms of the disease had not progressed far enough to obscure the pain resulting from some traumatism, which may have acted as the exciting cause of the Arthropathy. This brings us to a discussion of the Etiology and Pathology of these Tabetic joints.

It has been held by some, that these joints are the pure and simple result of intrinsic trophic changes brought about by Tabes. Others have insisted that traumatism is the prime factor in these developments, and have ignored the trophic influences, but as is usually the case, each observer seems to have held but half the truth. The spontaneous fractures observed in Tabetics, taken together with the rarified microscopic appearance of the bones, speaks strongly for true trophic changes; while the clinical observation that these joints seldom develop in the well-to-do, whose joints are shielded from traumatism in contra-distinction to the frequency of these Arthropathies among the laboring classes, points strongly toward the exciting influence of traumatism. We may then assume that two factors are present in the production of such joints, viz: (a) Trophic changes, and (b) Traumatism.

In speaking of the treatment of Tabes in general, it may be said that cure is impossible. There are some benefits however, to be derived from intelligent medical supervision of each case. There is a time when

a Tabetic is in a transitional period between Cerebrospinal Syphilis and Tabes. It is claimed by many excellent clinicians that the lightning pains and crises of Tabes, indicate active syphilis. If this be true, active treatment is indicated, and it has been proven clinically that Salvarsan and Heroic Mercurial treatment will in some cases relieve these painful phenomena. In Gastric crisis considerable benefit may at times be derived from ten drop doses of Adrenalin by mouth. The lightning pains and girdle sensations, may be relieved by occasionally making an intra-spinal injection of three-fourths of a grain of cacodylate of soda. For the inco-ordination in these cases, there is no treatment like continued active exercise, with a view to re-educating the muscles in matters of precision. Frankel has accentuated this idea in his elaboration of what are now known as the Frankel exercises, which consist of systematized calesthenic exercises, which the patient is required to go through for a prescribed length of time every day. This specific system is not necessary, but a system of exercises of muscular accuracy may be suggested by any physician, which will serve as well. One should always urge his patients to keep about on their feet and never give up, because once down, the powers of co-ordination fail rapidly. We now have under observation, three Tabetics who have suffered from Tabes for twenty years, and are yet walking well.

I will next present for your observation, two little boys, brothers, aged respectively three and eight. The family history is negative. There are no other members of the family similarly afflicted. This older boy began to show muscular weakness in the lower extremities and clumsiness soon after he had learned to walk, and this muscular disability has been steadily increasing. You will observe as he walks, that his gait is rather of a waddling character, and that flexion of the thigh upon the abdomen is not readily made. You will also observe much the same features in the smaller boy; only in a lesser degree.

Now the history of two boys in the same family, developing at about the same age, a progressive muscular disability would lead us at once to look among the so-called family diseases for our diagnosis, and in so far as the disease seems to be a pure muscular defect, we are justified in at least assuming until we prove otherwise, that we have two cases of Duchennes Pseudomuscular Hypertrophy.

You will bear in mind that in this disease, we have developing at an early age, especially in boys, a progressive muscular weakness, affecting especially the muscles of the thighs, calves, buttocks and back. Simultaneously with the beginning weakness, may be noticed an exaggerated pseudo-development of the muscular contours. The calves seem to be peculiarly well rounded, and the same may be said of the thighs and buttocks. The muscles in these localities, impart a firm

resisting, fibrous feeling to the hand, and yet withal, these seemingly well rounded muscles, possess no power at all. As a result of this weakness, the patient walks with a broad-based waddling gait; the toes do not readily clear the ground because of the patient's inability to raise the toes and flex the thighs. When standing, the pelvis tilts forward because of the failure of the hamstring muscles to guy the tuberischii down, and thus keep the pelvis in an upright position. This tilting of the pelvis, gives the patient a prominent abdomen, and a lordotic spine, which deformities are abolished when the patient is seated. You will observe that all of these features are present in these cases.

The most characteristic clinical demonstration which can be made of the muscular weakness in this type of trouble, can be brought out by having the patient lie upon the floor, and from that position, rise to an erect posture. We will ask this older boy to lie down. Now we will ask him to get upon his feet. You will observe that his first move is to turn upon his face, he then raises upon his hands and knees, then like a cow, he straightens up the lower extremities, in this way elevating the pelvis above the level of the shoulders. He now proceeds to place his hands successively upon different higher levels of the lower extremities, and in this manner, literally climbs up his own body. Now that his body is at a right angle to his thighs, he rotates the trunk on the thighs, and then swings to an upright position. This method of assuming the erect posture, is followed because the patient is obliged to use the unaffected muscles, as substitutes for those which are weak. The hamstring muscles have for one of their functions, the bringing of the trunk from a horizontal to a perpendicular, and this function being abolished, the patient is obliged to climb up his thighs to accomplish the same position.

Not long since, we had an opportunity to examine the muscles taken from a patient suffering from this disease, who died of an intercurrent malady. The Glutei and Gastrochnemii muscles were nothing but large masses of fat and fibrous tissue.

The prognosis in these cases, is usually bad. The trouble for the most part is progressive. The trunk muscles become affected, and the patient dies of some intercurrent disease, usually before maturity. Since the male individuals who have this disease become impotent, they do not propogate, but the females in these families, seem to transmit the disease to future generations. Therefore if possible, the girls in such families should be advised against matrimony.

The treatment for this trouble, promises little. Careful hygiene and attention to the general health is about all that can be advised.

The Fourth case which I wish to present, is one of Acute Adult

Poleomyelitis. My only reason for presenting this case, is that in his history, we have a record of retention of urine for a period of seven or eight days at the onset of his weakness. There are times when the acute infectious symptoms of Poleomyelitis cannot be differentiated from those of other diseases before the paralysis is observed. Retention of urine should immediately suggest either Poleomyelitis or Myelitis, and the latter can be excluded as a rule by the absence of anesthesias. The bladder trouble in acute Poleomyelitis abates in from five to twelve days, and its onset and duration in adults is an exceedingly characteristic symptom.

Dr. J. C. Rockafellow's Clinic at Mercy Hospital, April 17, 1912.

Case 1. Exophthalmic Goitre.—A colored boy, age 16, who for several years past has noticed an enlargement of the right lobe of the thyroid gland. About six months ago the enlarged lobe began to increase in size and symptoms of hyperthyroidism developed. Tachycardia is the most pronounced symptom, the frequency of the heart beat being from 108 to 130. There are at present no signs of dilatation of the heart or degeneracy of the heart muscle. Exophthalmos is present but not to a marked degree. We have been unable to determine the presence of any tremor. This patient has been subjected to medical treatment, including a protracted rest, but his symptoms have not materially improved. It is our intention to remove the enlarged lobe of the thyroid with the hope of relieving the symptoms of hyperthyroidism.

Operation.—After making a collar incision and separating the sterno-hyoid and sterno-thyroid muscles, we find it impossible to deliver the lobe of the thyroid. The muscles are divided and the right lobe and isthmus removed but not without difficulty on account of hemorrhage. The divided muscles were sutured, a rubber drain inserted and the wound closed.

Cases 2 and 3. Chronic Appendicitis.—Two sisters age 10 and 18 respectively, who have suffered repeated attacks of pain in the abdomen, associated with nausea, vomiting and tenderness in the right iliac fossa. In the case of the elder sister the condition has existed for three years and the number of attacks has averaged two annually. The younger sister had her first attack nine months ago and is just recovering from her second attack. These are typical cases of chronic recurrent appendicitis and it is our intention to remove these appendices through right rectus incisions. This is our routine practice in all cases of appendicitis occurring in females, in order that the pelvic viscera may be more readily inspected.

Case 4. Arthritis Deformans.—This man, age 28, had been afflicted for twelve years with Arthritis Deformans. It first started in

the joints of the feet and hands though many of the joints of his body are involved at this time. He consults us not with the idea of having the condition cured but with the hope of relief from the deformity consequent to the disease. This deformity is manifest particularly in the feet and we find the patient unable to wear shoes on account of the angular deformity at the metatarso-phalangeal articulations. We hope to rectify the deformity to such a degree that shoes may be worn and the patient's gait improved.

Operation.—The head of each first metatarsal bone was resected, the bursa interposed between the metatarsal bone and the phalanx and the second and third toes amputated at their metatarso-phalangeal articulation.

Dr. O. J. Fay's Clinic, Methodist Hospital, April 17, 18, 1912.

Case 1. Chronic Appendicitis. Mr. W. P., 60, mason. Always well until 3 years ago—typhoid fever, good recovery. First noticed a dull aching pain in the abdomen 12 years ago; it persisted and during the past few weeks he has had several acute exacerbations with vomiting, fever, and abdominal rigidity.

Good heart, lungs, and arteries; fair musculature; urine negative; tender over right iliac fossa.

Operation appendectomy. Adhesions present. Good recovery.

Case 2. Chronic Appendicitis. Mr. F. L., 28, Italian fruit dealer. This is his first serious illness. About one year ago soreness appeared in the right lower side of the abdomen and has kept up ever since; never very severe or accompanied by vomiting or temperature though it interfered with his work; worse when constipated.

Well-nourished; right side somewhat rigid and tender.

Operation. Appendectomy. Result good.

Case 3. Recurrent Appendicitis. Miss P. E., '13, school-girl. Diphtheria several years ago (good recovery) and constipation, the only previous ailments. Six months ago a dull pain began in the gastric region, persisted without other symptoms until a month ago when there were a number of acute attacks accompanied by vomiting and fever. The last attack was five days ago and was the severest—temperture 101.

Present symptom tenderness and rigidity over McBurney's point, and temperature 99.

Operation: Appendectomy. Appendix had perforation sealed by omentum. Drained. Good recovery.

Case 4. Myomatous and Prolapsed Uterus, Chronic Appendicitis. Mrs. J. R. M., 45, housewife. Family history negative; not strong as a girl; menses scanty, regular, and painful. Married at twenty-three.

two children both of normal birth; since then always well until present illness.

About ten years ago she began to flow excessively at menstrual periods, had backache and frequent occipital headaches. These symptoms have persisted and grown worse.

Well-nourished woman, chest normal; tenderness over appendiceal region; uterus enlarged and prolapsed to moderate degree; has several nodules on it.

Operation: Supravaginal hysterectomy, appendectomy. Result, good.

Case 5. Retroversion and Prolapse of Pregnant Uterus. Mrs. C., 32, housewife. Well until married. Has three children, 2 to 8 years old, births normal except for laceration with first; not well since then.

For several years pain in lower lumbar region and pelvis; worse lately; constipated; occipital headaches; nervousness; loss of flesh; painful menses, last seen two months ago.

Musculature poor; chest negative; lax abdominal walls; perineum moderately lacerated; uterus prolapsed, retro-verted, enlarged, pregnant.

Operation; Baldy suspension of uterus; chronic appendix freed from adhesions and removed. Result good recovery; pregnancy not interrupted by operation.

Case 6. Prolapsed Uterus, Lacerated Perineum. Mrs. R. N. H., 31, saleswoman. Always well until married; one child born ten years ago, spontaneous birth with much laceration; primary repair failed. For the past five years pain in the lower lumbar region and weight in the pelvis; occipital headaches and vertigo; menses normal. Chest and abdomen normal. Moderate laceration of the perineum; uterus prolapsed with cervix almost to outlet.

Operation: Baldy suspension of uterus, and perineorrhaphy. Result good, recovery rapid.

Case 7. Cholelithiasis. Mrs. E. A., colored, 42. Six children; always well except for present trouble.

For several years pain in the right hypochondrium—colicky, very severe and radiating to the right shoulder; vomiting; often chills and fever; whites of eyes yellow.

General examination negative. Gall bladder region very tender; sclerotics yellow.

Operation: Cholelithotomy and cholecystotomy, two large stones in cystic duct. Result—rapid recovery.

Case 8. Cholelithiasis, suppurative cholecystitis and choleangitis, and hepatic abscess. Mrs. G., 48, housewife. Had always been well. Two children. Family history negative.

Present illness began about five years ago with cramp-like pains in the right hypochondrium, radiating to right shoulder, back, across to left and downwards. Morphine was required. Jaundice followed attack. Has had a number of attacks since, the last one ten days ago accompanied by chills, high fever, exhausting sweats. The chills recurred once or twice a day and the pain became a severe aching in the upper right side.

Jaundiced; temperature 100 to 104., pulse 85 to 112, respiration 24. Great tenderness and marked resistance in the region of the gall bladder. Blood count leucocytosis of 20,000.

Operation: Cholelithotomy. Stones removed, gall bladder full of purulent and degenerated bile, gangrenous part of gall-bladder removed. Gall bladder packed with yellow gauze and allowed to drain.

Result—For several days the patient improved, then there was a return of the chills, followed by high fever and exhaustive sweats. This continued for about six weeks, tenderness over the liver and leucocytosis persisted, until patient returned home where she died about a month later.

Case 9. Subacute Osteomyelitis of Right Radius. C. W., boy aged 9. No tuberculosis in family.

About five years ago the boy fell injuring arm just below the elbow, apparently no bones broken. Primary injury disappeared but the arm later became painful and somewhat swollen; continued in this condition until ten days ago when an abscess broke spontaneously over the radius about two inches above the wrist.

The boy is of average size, in good health except for the right arm which is swollen and indurated, especially over the lower two-thirds of the forearm; much redness and two sinuses present along the radius near wrist; radius apparently elongated causing ulnar deviation of wrist and hand. X-ray shows the bone thickened, elongated, and crooked.

Operation: Curettement of diseased bone, and drainage.

Result: After two months of dressing and treatment the arm became softer, less swollen and there was some straightening and shortening of the bone; hand less deflected, function better, general health fine.

Microscopic examination showed only necrosis; no micro-organisms found, propably was a staphylococcic infection.

Case 10. Cleft Palate. H. M., boy-infant aged 5½ months, always well.

Hare-lip and complete cleft palate through the left nostril, present since birth. Nursed without difficulty; has had no manual treatment.

Anaesthetic—Chloroform.

Operation—Owen hare-lip operation and typical Brophy uranoplasty, and staphylorrhaphy.

Result perfect, except uvula.

Case 11. Four weeks old supracondylar fracture with bad position. Master H. P., 7, schoolboy.

Four weeks ago the patient fell striking on right elbow. Attempt at reduction made and splints applied; four weeks later there was no function and the X-ray showed marked backward displacement of the elbow, and union in this position.

Operation—Fracture opened, union broken up, reduced, and Lane plate applied, then cast.

Result—Six weeks later the bone plate was removed, good union and very fair function.

Case 12. Mrs. F., 60, housewife, stout. No cancer in family. Always well until one year ago, except sciatica of left side, still sore.

About one month ago the patient noticed a bloody vaginal discharge, pain on urination and defecation, and pelvic distress. No loss of weight or strength.

Vaginal examination reveals a mass arising from the cervix and involving the whole uterus and the vesical and rectal walls. Entire pelvis fixed.

Operation—Actual cautery.

Result—Temporary stay of symptoms.

Dr. H. A. Minassian's Clinic at Mercy Hospital, April 17, 1912.

Case 1. Tubercular appendix. Has been a patient at Ridge Camp for one year for the treatment of pulmonary tuberculosis. Distress in right iliac fossa for six months without acute crisis. Operation. Abdomen opened through a right rectus incision. Uterus and adnexa normal. Nodular and thoroughly adherent appendix with its mesenteriolum was removed in the usual manner. Lymphatic involvement slight. Tube drain placed and removed in 48 hours. Complete recovery.

Case 2. Diffused tubercular peritonitis. Miss P. D. age 18. Family and previous history negative, but patient was never robust. Present symptoms date back to February, 1912, consisting of severe and diffused pelvic and abdominal pain and marked febrile movement. Patient is imaciated. After noon temperature has ranged from 102° to 104° F. Operation. Abdomen was opened in median line. Parietal peritoneum, omentum and mesentery and all abdomina viscera were found studded with miliary tubercles and thoroughly adherent. Moderate amount of serous fluid was present in the abdominal cavity. After breaking up some of the adhesions the fluid was gently wiped

out. Drainage placed and maintained for one week. Patient recovered from the operation with marked improvement of symptoms.

Dr. W. S. Conkling's Clinic at Methodist Hospital, April 17, 1912.

Case 1. J. T. age 20 taken suddenly ill with severe pains in abdomen, accompanied with vomiting. Temp. 99.3. Pulse 86. During last 18 months patient gives a history of having had three similar attacks.

Ex. well nourished. Chest findings negative. Abdomen rigid especially over right lower quadrant. Very tender over McBurney's point. Right rectus incision 36 hours after onset. Appendix found adherent throughout, deeply congested and swollen. Appendix removed in usual manner. Stump cauterized, inverted and buried with purse string suture. Abdominal incision closed, no damage. Post Operative. Course uneventful. Left hospital on 12th day.

Case 2. Mrs. I, aged 26, married, three children, 3-5-7 years. Two miscarriages—last one six months ago. Patient complains of a great deal of pain in back and radiating downward into thighs which is greatly increased upon standing, exertion and at menstrual periods. This condition has been present for past two years.

Ex. Patient anemic, chest findings negative, abdomen relaxed, a great deal of tenderness in left lower quadrant of abdomen.

Vag. ex. Cervix tilted, pointing upward and forward. Fornices clear, right side negative. Body of uterus found low down in hollow of sacrum. Mass in left broad ligament.

Diagnosis. Retro displacement of uterus and cronic salpingitis. Median incision, appendix removed left tube found inflammed and was removed together with cystic left ovary. Uterus brought up and suspended with the round ligaments by Gilliam's method. Abdomen closed in usual manner. Time of operation 45 minutes. About eight hours after operation patient went into profound shock. Normal salt solution was given by rectum and hypodermoclysis to which patient responded nicely. Convalescence was rather slow due to anemic condition. She is now fully recovered and doing her own work with comfort.

Dr. C. E. Ruth's Clinic at Mercy Hospital, April 18, 1912.

Case 1. Right oblique inguinal hernia in a male nineteen months old. The operation consisted of separating and ligating the hernial sack and after ligating the neck of same it was secured above the internal ring behind a strong part of the abdominal wall and the cord was placed entirely within the abdomen and the conjoined tendon united to Poupart's ligament, the apponeurosis of the external oblique was overlapped ½ inch and the cord made to climb up over the pubes.

Union was secured throughout without a drop of pus and the patient was discharged well on the tenth day. Phimosis in this case was relieved by dilatation and freeing of adhesions. There was no post-operative vomiting in this case. Operative time thirty minutes. Anaesthetic ether, No other drugs were given.

Case 2. Right oblique inguinal hernia in male aged fifty three. The operation consisted of freeing the hernial sack and after ligation, the neck of the sack was secured above the inguinal canal behind a strong part of the abdominal wall. The conjoined tendon was sutured to Poupart's ligament behind the cord, the apponeurosis of the external oblique was overlapped ½ to ¾ of an inch in front of the cord. Union was immediate without inflammation, pain or pus formation and the patient was discharged well on the sixteenth day after the operation. There was no post-operative vomiting with this case. The operative time was thirty minutes. Ether was the anesthetic used without any other anodyne before or after operation.

Case 3. Operation was for retroflexion of the uterus in a woman twenty-seven years of age the mother of two children she was also suffering from floating kidney on the right side and a perineal laceration. The operation consisted in shortening of the round ligament supports by using the folded strongest internal or uterine extremity according to the plan practiced by Todd-Gilliam and modified by Mayo in which the folded ligaments are united in front of the rectus abdominus. Five days later we did a fixation operation on the right kidney and a perineorrhaphy. All the wounds united without suppuration or pain. The patient was discharged well the twenty-fourth day after the first operation. Time of the first operation was thirty minutes. Ether was the anesthetic used. No vomiting occurred after either operation.

Case 4. Left oblique inguinal hernia in male six years old. The operation in this case was essentially the same as in case one. The second day the temperature reached one hundred and two without apparent cause. Nausea and vomiting took place occasionally for five days following the operation though he had had considerable digestive disturbance for some time before. Union took place without incident, inflammation or supuration and he was discharged well on the thirteenth day after operation. Operative time thirty minutes. Ether was the anesthetic used.

Case 5. Male aged thirty-nine operated upon for chronic appendicitis and exploration of the gall tracts on account of recent cholecystitis and icterus. Vertical incision was made through the right rectus. Appendectomy was done by ligation and inversion of the stump. Recovery was without incident and union was by first intention. Discharged well on the 21st day after operation. Had we made the grid-

iron incision in this case we could have saved him two weeks of time in the hospital but we would not have had the satisfaction of a knowledge of the complete recovery, apparently, from the former attack of cholangitis.

Dr. W. W. Pearson's Clinic at Mercy Hospital, April 17, 18, 1912.

Case 1. Cataract extraction with iridectomy—The patient was a man ninety years of age; there was nothing unusual in the operation. It was worthy to note that the course of healing was similar to that of patient thirty years younger.

Case 2. Was the removal of an eye with a large straphylomatous cornea, from a man 50 years of age. Had been blind for years and only recently, following an accidental blow had become acutely inflamed, causing the patient a great amount of suffering and loss of sleep. The condition of the other eye was normal.

Case 3. Was a plastic operation for the correction of a spastic entropion. The patient was a lady fifty years of age; had been annoyed by the condition for several years. The operation was performed under local anaesthesia. The result is very gratifying and apparently a permanent one.

Case 4. Was the opening up and cleaning out an ear that had been operated on radically by another surgeon several years since for a complication following a scarlet fever infection. The boy was ten years of age. A spicula of necrotic bone was removed.

Case 5. Was a double entropion operation following trachoma of several years standing. The patient was a woman fifty years of age. The operation was performed under local anaesthesia. The result has proved to be satisfactory.

At the regular clinic at the Dispensary about forty-five patients were shown. Fourteen minor operations were performed most of which were tonsil and adenoid operations. In the tonsilectomies the snare was used; the tonsil with the capsule was removed in each case.

Dr. Arthur Steindler's Orthopedic Clinic at Iowa Methodist Hospital, April 17, 18, 1912.

The following cases were demonstrated:

1. Miss C. G. case of rheumatoid Arthritis of 7 years standing. The contracted knee joints were broken up repeatedly with the result that patient walks straight and comfortably and is able to do office work.

2. R. B. and E. H. 5 and 4 years old, cases of Spastic paralysis (Littles disease). These cases were considerably improved by a plasty of the tendo Achillis, with lengthening of the same.

3. L. C. 12 years, a case of Tuberculosis of the right sacre-iliac junction. The patient was in plaster cast for several months and has improved to the extent of being able to walk and play, and is free of pain.

4. The technic of the Lange Celluloid wire insels was demonstrated with special reference to the support of the anterior metatarsal arch, and a case of relaxation of this arch due to Rheumatism was demonstrated.

B. Operative cases: 1. G. C. Congenital clubfoot. Was operated on several years before, but recurred. In ether anaesthesia the Lorenz Method of unbloody redressment of the deformity was used. Then the tendo-achillis was divided and the correction maintained in a plaster of paris cast.

2. D. C. 3 years old infantile paralysis, of 1½ years standing.

The left foot is a pes calcanvalgus paralyticus. For the correction of the valgus deformity a tendon transference is performed with the following technic:

Longitudinal incision over the ankle joint in front of the extensor muscles. The extensor proprius hallucis and the common extensor of the toes were isolated, part of the latter and the whole of the former muscle were severed as far distally as possible and with strong silk sutures secured to the periosteum of the scaphoid on the inner side of the feet. In this way a substitute for the paralyzed Anterior Tibial muscle was created.

Report of the Afternoon Session of the Alumni Association.

At the first afternoon session the following papers and demonstrations were presented.

Professor F. J. E. Smith demonstrated some of the recent tests which have been developed in urinary analysis. This was done in the new rooms now occupied by the department of chemistry; and the advantages of the new quarters and equipment served the occasion well.

Professor P. E. Lineback occupied the next period in giving a resume of the work in anatomy on the bundle of His, demonstrating several excellent dissections of the heart, both injected and not, and also cleared the subject further with blackboard drawings and microscopic sections.

Professor A. S. Begg showed a series of slides of a big embryo such as each student now uses in class work, using the micro-progection apparatus. The use made of material was explained, and the need of young embryos for the collection, shown.

Professor W. L. Mendenhall made use of a class demonstration to show the action of the heart valves. A heart with a circulatory system

of tubes, containing water was so arranged with windows in the walls and electric lights so placed, that the actual workings of the valves were shown.

The second afternoon was likewise spent in demonstrations and the reading of papers.

Dr. C. E. Ruth showed his well known method of treating fractures of the hip. Having provided a table with all the necessary pulleys, weights, etc., the demonstration was very vivid and instructive.

The description of the appliances and cuts illustrating same will be given next month.

Professor D. J. Glomset showed what was being done in the department of pathology by showing specimens from a few of the most recent autopsies conducted by the department. Both gross and microscopic preparations were used, using the micro progection apparatus to an advantage. The great need of more work along these lines was admirably shown.

Dr. J. H. Peck read a carefully prepared paper on incipient tuberculosis bringing before us the results of work being done at Ridge Camp under his direction and showing the strides made in this community since the establishment of the camp and its relation to the school.

A. S. Begg, M. D.

Professor D. J. Glomset, Drake Alumni Clinic.

Carcinomitous Organs from an Autopsy Demonstrated.—The case was a carcinoma of the liver, primary in the gall bladder occurring in a woman 69 years of age. The clinical aspect of the case was perfectly typical viz., the gradual increasing tumor in the left side of the abdomen, was associated with loss of strength and flesh and with persisting pains which did not yield to treatment.

The organs showing lesions were demonstrated both gross and microscopically. In the gross way the tumor was shown to have started in the fundus of the gall bladder and from there had extended into the liver by direct continuity and by the involved lymphatics. The liver was greatly enlarged extending into the true pelvis. It was nodular on the surface. The nodules varied in size; from the size of a pea to that of a walnut. A number of the gray nodules showed typical cancer umbilication. The tumor had extended into the head of the pancreas and had involved most or the mesenteric glands which were enlarged and firm. The receptaculum chyli was shown to be enlarged and its cavity obliterated by tumor tissue. Malignant thromni appeared in the thoracic duct, and lymph glands and the root of the left lung were large and firm.

Microscopically the structure of the malignant growth was demonstrated by means of a lantern. The carcinoma had started in the mucosa of the gall bladder in one of the mucus glands. This had become enlarged, its cells had increased in number, rapidly had filled the lumen of the gland and then grown wild in the muscular coat of the organ. The tumor cells were seen to crowd the lymphatics running from the gall bladder. The malignant growth in the liver was shown to have the same structure as the parent growth in the bladder. It was a typical adeno-carcinoma. The umbilications proved to be necrosis of the cancer tissue. The thrombi in the thoracic duct and the foreign elements in the lymph glands proved to be of carcinomatous nature.

THE TUBERCULOSIS DISPENSARY.

JOHN H. PECK, M. D., DES MOINES, IOWA.

The establishment of the special tuberculosis dispensary, as a most helpful agency in the organized crusade against tuberculosis, has been much neglected, especially in the West. That it may be of great value is admitted by all who have made any extensive study of the subject.

The dispensary dates from the well-known work of Philip[1] of Edinburgh, who established the first strictly tuberculosis dispensary at the Victoria Hospital in 1887. He has recently stated that its work is still increasing and concludes that no one factor is more important in stamping out the disease. His observations and practical experience, extending over a quarter of a century, are particularly valuable.

Nowhere is better organization for the accomplishment of definite results or public support more liberal than in Massachusetts. The Boston Dispensary was established in 1899, being the first of its kind in the United States. Cabot[2] maintains that the essentials of a tuberculosis dispensary are (1) a physician who knows tuberculosis thoroughly and is willing to give his time for a few hours a week to the examination of suspected cases and the general supervision of their treatment: (2) a nurse or trained visitor who will carry out in the homes of the patient, the details of the physician's instructions: (3) for the support of the undertaking, a fund of about one thousand dollars per year.

The second dispensary opened in this country was in Chicago, about five years ago, and now all such clinics are organized into the Chicago Tuberculosis Institute, operating dispensaries in connection with the leading medical schools and hospitals. Klein[3] states that a vast amount of good is being accomplished and outlines the functions of the dispensary as follows:

1. To care for ambulatory cases.
2. To refer incipient cases to Sanatoria.
3. To refer advanced cases to suitable hospitals.
4. To watch and supervise cases discharged from Sanatoria.
5. To examine other members of the family.
6. To disseminate information.
7. To aid the Health Department.

The Association of Tuberculosis Clinics was formed in New York in 1908, and now includes 126 philanthropic institutions, which annually treat over 30,000 cases. The city is divided into districts and the work is splendidly and economically done. Franchere[4] claims that the system depends on two factors—one is the exactness of the methods of diagnosis and treatment and the other is the ability to supervise the patient. The former means that competent physicians must be in charge

of the dispensaries, and the latter that all patients must be followed into their homes by specially trained nurses, who show them how to avail themselves of the best opportunities for taking the cure that their homes afford. Further, those members of the family who show any suspicious symptoms, are encouraged to come to the dispensary for a thorough examination in order to discover the disease while it is still in its early stages.

You are perhaps more interested in knowing how the plan works out with us in Des Moines, although our organization is not fully perfected in several of its most important details. We have no special tuberculosis nurses and in the past have been compelled to rely largely upon the assistance of two visitors from the Associated Charities and the three school nurses employed by the school district. They, of course, have had many routine duties and very little time to devote to our cause. A movement has been started, however, whereby we may have at least one special tuberculosis nurse and thus increase our efficiency. The benefit of these specially trained nurses or visitors cannot be too strongly emphasized, for you will note that our lack of a "follow up" system has been one of our weakest points. A large per cent of our cases have been seen but once in the dispensary, and then disappear. On account of our lack of sufficient assistants to follow these patients into their homes and ascertain the conditions under which they live, the economic proposition they must face, their hygienic or unhygienic manner of living, the varied sources of infection or lowered resistance in the home and to devise and put into operation some plan of education or alleviation of existing conditions, our records are necessarily deficient in many of these details.

Since our Tuberculosis Dispensary was opened less than a year ago in connection with the Free Dispensary of Drake University, College of Medicine, we have had 145 admissions. Many of these were referred for diagnosis only, some for reference to the State Sanatorium and a considerable number from the various departments of the general dispensary for examination. I have tried to show by the diagram the principal sources of reference of these patients.

City Health Department	6	4.1%
County Health Department	4	2.8
Associated Charities	26	18.0
Other Charities	10	6.9
School Nurses	10	6.9
Medical Dispensary	24	16.3
Other Dispensary Service	14	10.0
General Public	11	7.6
Physicians	32	22.0
Sanatoria	7	4.7
Teachers	1	0.7
	145	100.0%

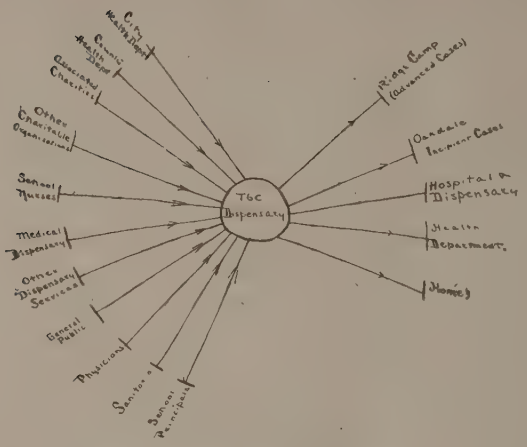


Chart showing sources from which patients are referred to the dispensary and their disposition after being discharged.

You will note that more than one-fourth of our cases came through the regular channels of our general dispensary. This indicates the advantage of the affiliation of the tuberculosis dispensary with such an institution. However, with the proper arrangement with charitable organizations, school nurses, physicians and the evident appreciation on the part of the general public, this relationship is not essential. A sufficient number of patients may be referred in any large city to fully prove the great need of a tuberculosis dispensary.

We have found that the proper disposition of our patients was a most trying part of our work. Many of them are seen but once, at which time a positive diagnosis could not be made. Many others, on being told that they were suffering from pulmonary tuberculosis, immediately proceeded to find some physician who, through ignorance or deception, would assure them that they had simply a bad cold, or bronchitis, or stomach trouble or were in a run-down condition. Again, many patients are positively informed that the presence of a few tubercle bacilli does not mean anything. Our motto has been, agreeing with Jessen[5] "that there should be no shrinking from labeling tuberculosis with its proper name while preaching its curability." Recently an osteopathic practitioner told a woman patient of mine, whose husband had died ten days previously from pulmonary hemorrhage, that she had catarrh; that Doctor Peck was not a graduate physician, was only a student, hence could not be expected to diagnose consumption.

A number of our cases have fallen within the sphere of the surgeon and have all received much benefit from operative procedures. We have had tuberculosis of the cervical glands, kidney, epididymus, prostate, and the ovary, treated surgically with gratifying results.

Our salvation in the disposition of patients has been the existence in Des Moines of a sanatorium for cases in any stage of the disease. This institution, known as Ridge Camp, is operated by the Associated Charities, and has a maximum capacity of fifteen patients. Many have been sent there pending admission to other sanatoria or for observation. We have the entire medical supervision of Ridge Camp, with sole power to admit patients, and have achieved some marked results, considering the type of patients sent there. Most of the incipient cases are referred to Oakdale, where we feel they have a better chance of recovery on account of better quarters, more trained assistants and best of all, more money.

The State Sanatorium for the treatment of tuberculosis located at Oakdale, near Iowa City, with a capacity of one hundred and twenty patients, has also rendered valuable assistance. It was by the influence and under the direction of the late superintendent, Dr. H. E. Kirschner, that our dispensary was started, and we have found his advice very stimulating. They have always made room for a worthy case whenever we have requested it.

We never advise a tuberculous patient to change climate for the benefit of his health, unless he can show the financial ability to take the treatment properly. This accounts for so few cases leaving the state. So far as our records show, one each has gone to Minnesota, Kansas and Illinois, two have gone to Colorado, and, curiously enough, one has come here from her home in Denver and is now doing well at Ridge Camp.

Several have received tuberculin injections at the dispensary; at least three or four cases have shown marked improvement. About twenty-five per cent have had treatment for pathology of the nose or throat, and usually their general condition has improved.

One pleasant feature of the work is the relatively large per cent of patients who are discharged as non-tuberculous. This could be much increased, if a greater number of those who come for diagnosis, would return for subsequent examination. Most of these non-tuberculous cases were children who suffered from mal-nutrition, or adults with emphysema, asthma, chronic bronchitis, neurasthenia, goitre, lues or aneurism. Of the series of 145 cases, our diagnoses are as follows:

Non-tuberculous	44	31%
Tuberculous	90	62
Suspicious	11	7
	145	100%

Summarizing the disposition of patients, our results show as follows: Several were disposed of more than once.

Ridge Camp	35	22.2%
Oakdale	15	9.5
Hospital and Dispensary	11	6.9
Home and Farm	14	8.8
West	5	3.2
Disappeared	23	14.6
Non-tuberculous	44	28.0
Suspicious	11	6.8
	158	100.0%

The number of disappeared cases is much too large and emphasizes the great need of special nurses or trained visitors to follow these patients into their homes and thus keep track of them.

Inorder to render the greatest amount of good in this crusade, a thoroughly organized plan of operation is required, with co-ordination of measures in respect to the different aspects to be faced. Since 1897, reports of tuberculosis cases have been compulsory to the Health Board of New York and the law has been successfully enforced. Many other cities have followed this plan. Why should not the disease which causes one-seventh of the total mortality of the civilized world, besides a vast economic and social loss, be reported to the health authorities, as well as any other infectious disease? Such laws are necessary in all states and will greatly facilitate the problem of discovery of early cases and the enforcement of precautionary measures for those associated with the individual.

CONCLUSIONS.

1. The measure of success in the anti-tuberculosis campaign is governed by the degree of completeness and efficiency of the methods used.

2. The dispensary cannot fill its greatest measure of efficiency until compulsory notification is required.

3. Any city can successfully operate a tuberculosis dispensary with a small outlay of time and money.

4. The dispensary must be made the "clearing house" for all tuberculosis cases, especially among the poor, and as such fulfills its greatest function.

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Dr. C. M. Wert's Clinic at Methodist Hospital, April 18, 1912.

Mrs. H. S., age 35. Cataract of left eye operated two years ago. Ripe cataract of right eye operated today. Extraction with Iridectomy. July 18-1-12 with + 7.50 + 3.0 ax 165. Vision 6/6.

Mr. J. F. O'B., age 78. Epithelioma of lids of left eye involving all of both upper and lower lids including the caruncle extending up to the brow over both outer and inner canthus. Exentratio orbitae removing both upper and lower lids bringing down a flap from above and one from below covering the orbital cavity leaving small opening at inner canthus through which the orbit was packed until filled.

First Evening's Program.

The first evening of the Drake Medical Alumni meeting was given over to the general get-to-gether assembly. The alumni and faculty met in the auditorium of the medical college about 8:30 o'clock. Dr. C. F. Smith presided and called upon President Bell for an address of welcome.

The president in his address gave hearty welcome to the members of the alumni association, wishing them much pleasure and profit from the few days meeting. He spoke of the relation of the alumni to the University and of the necessity that each one should be a booster in earnest.

He called attention to the numerous changes in the last few years. How the college had arisen from seeming abandonment to one of the highest rank. He spoke of the policy of the new school, progressive in every way, striving at quality rather than quantity in output. He called attention to the new laboratories and their equipment; the dispensary and the increase in number of patients over previous years. He closed by paying high tribute to Dean Pearson; to whose leadership he attributed the greater share of honor for the new order of things.

Dr. John Cahill responded for the alumni, remarking on the change in the school for the better, the increased feilities for high class work. He spoke of the clinics and of the pleasure he had in meeting faculty and old schoolmates, feeling amply repaid for the time spent in attending the association.

The assembly was then delightfully entertained by the Drake Male Quartette whose numbers were enthusiastically received by all present.

Two excellent papers followed: The first "Salient Points in Diagnosis and Treatment of Urinary Diseases," by Dr. Ben C. Everall of Waterloo; and the second "Rheumatism in Children," by Dr. Frank M. Fuller of Keokuk. Both papers were well written and showed careful thought and preparation. They were discussed by several members present.

Dr. Pearson was called upon for a short talk in which he confirmed President Bell's statement that the school was a permanent organization and that it would always be at the top in first class work.

The meeting was then adjourned to the library room where a buffet luncheon was served and a congenial hour spent in reminiscence.

J. Arthur Downing, M. D.

The Banquet of the Drake Alumni Association, April 18, 1912.

Shortly after eight o'clock the banquet doors opened and the guests filed in. Chairman Dr. C. F. Smith called to order and Rev. Finis Idleman invoked divine blessing. Fully a hundred persons were seated at the tables. Wives and friends accompanied several of the doctors, but most of the number were alumni of the school. After the meal the Chairman introduced Dean W. W. Pearson who responded with, "The Future of Our School."

"Our whole aim is for advancement," said he.—"Our standards and ideals are high, and we are not leaving any thing undone which is conducive to this end."—The dean spoke quite at length upon the growth during the past few years. Six years ago the dispensary was hardly more than a name. Few cases came to the building and most of these were of minor import. The outpatient department was practically nothing. Even the dispensary staff felt a weight of indifference and monotony hanging over the work. Inadequate equipment and lax organization lent small impetus to live energetic work.

Through recent years a new spirit has been working mightily for efficient and gratifying ends. Today instead of inadequate non-frequented clinic rooms, large fully equipped suites are crowded. The whole school has been consolidated and established in the one building. To meet the need of this advanced step the building has been enlarged to three times its former size, and laboratories of the most modern type have been installed, so that every phase of advanced work may be done here. Men are eager to serve on the dispensary staff, while the regular members are vying with each other to advance the welfare of the institution. "Any staff member who does not put the interest of the school before his own interest has no place there, and will soon find his way out."

"We are determined to make this not the largest but one of the best schools in the country. Our entrance requirements have been raised to the two year college standard. Our laboratories are fully furnished with best appliances. We are establishing young men as instructors, men who are moved by the spirit of work rather than show. They are studying in the best institutions and are directing their own work in accordance with these.

"There are," said he finally "still many needs and we are a long

way from our ultimate goal, but when the way is clear and the time is right the means will be forthcoming."

The chairman then introduced former Dean Fairchild who spoke on the theme, "The Past." In a unique and pleasing way Dean Fairchild bore emphasis to the fact that the glories of modern and recent achievements have had their meager beginnings. Especially of interest were the events of the founding and early days of the school.

"While waiting for this evening's meeting, and planning what I should say, I went, this morning, to the Dispensary Building. I wondered at its splendor but I asked in vain if any one knew where the old Iowa Medical College was?" He then visited the magnificent Mercy Hospital, and was deeply impressed with it, but no one could tell him where he could find the Cottage Hospital.

He then related the incident of how he with a few others rented a second story room of the Turner Hall on West Court Ave. near the present site of the Register and Leader office. They made small appartments with rough lumber. One sink served for the general use. This was during the summer of 1882 and that fall twelve students entered for the course of two lecture terms of six months each.

In 1892 after ten years of work the school then under the leadership of Dean Schooler became affiliated with Drake University, Dean Fairchild assuming the office made vacant by the resignation of Dean Schooler.

In the presence of these modern achievements no one is unmindful of the noble past. The city thinks with pride of these days and events of heroic struggle. Des Moines and Iowa gladly stop to honor Dr. Fairchild and his worthy associates of those times, such men as Drs. Schooler, Blanchard and Priestley.

Dr. Frank Fuller of Keokuk was then introduced but on account of the lateness of the hour and his modesty he only responded with a few general remarks.

Dr. Fuller's presence at the clinic was greatly appreciated. He is a wide awake man and has the happy faculty of mingling humor with his work. The association feels that it can expect much from him and his rich experience.

The assembly then took up the business matters of the association. With spirited but friendly contention Dr. Wilbur Conkling was elected president. The chairman then had him escorted to the chair by Drs. Duhigg and Burcham. Here President Conkling made a few general encouraging remarks and proceeded with the election. Dr. Fuller was unanimously made Vice-President.

Then, with applause, Dr. Mountain's name was proposed for secretary. President Conkling with some animation praised the untiring

work of Dr. Mountain and called for a vote of thanks of the house to him, which was extended with prolonged cheering. To Dr. Mountain's unceasing work and unyielding faith was due the greater part of the success of the clinic. The association applauded the man and congratulated its self upon what it could expect for next year. Through his energies it is hoped that a greater number of the alumni will become active in the interest of the association. The meeting adjourned in enthusiastic resounding of the watch word "A greater clinic next year, a greater alumni association, and a greater Drake Medical College."

PAUL E. LINEBACK, M. D.

The Future of the Drake Medical Alumni Association.

The past history of the Drake Medical Alumni Association is of interest only as a reminiscence, and of value, only on account of the lessons learned.

The future is of greater moment now, and it will be what the Alumni Association makes it.

It can be one of the great powers in the State of Iowa for the advancement of medical science, and the agent in procuring legislation on all matters pertaining to public health and medical education. In fact, it can set the standard for medical qualifications within the state. But if it is going to be a live organization and accomplish great things, it must stand for something, no association or society ever existed for any length of time, unless it had a purpose in view, or a principle to stand for.

A large army without drill or without an enemy in front of it, would soon disintegrate into a disorganized mob. So with this association, if it does not have things to accomplish, something to do, it will disintegrate. What then, shall be its work?

In the writers mind, the purpose of the organization, should be to increase the efficiency and standing of the members. There is nothing which gives the same amount of credit to an institution, as a large number of competent, honest and truthworthy graduates, who are doing their share of the worlds work in promoting health, happiness and prosperity, and at the same time doing their part in advancing medical science.

If the members of the association are to be successful medical men and women, they must co-operate with each other. There is no more practical method of doing this than that of holding yearly meetings at which time papers should be read and clinics held. These clinical meetings can be made so valuable that no one will care to miss them if it is possible to attend. Care should be taken in the holding of these clinics, to prevent any individual or clique of individuals from using

the clinic, or association to further individual interests for personal gain and selfish motives. The stamp of disapproval should be placed upon graft and quackery where ever they appear in the profession.

Let it be known that a graduate of the Medical Department of Drake University, stands for a principle which is paramount to everything else.

Make it a rule to say a good word for him whoever or wherever he is, providing he is honest and is doing his best. If the association is going to live, it is necessary that all who have not joined, should do so at once. Co-operation by all is necessary, and each and everyone should give their moral as well as material support.

Commence today to prepare a paper or the report of an interesting case. Send in some cases for the clinic, and make up your mind that you will not allow anything to interfere with your attendance at the next meeting.

The officers will put forth their best efforts to make the next meeting a still greater success, and trust that you will show your appreciation by your attendance.

WILBUR S. CONKLING, M. D.

Man attracts attention at his birth, at his wedding and at his funeral—three times and out, as it were.

You have to go after what you want; it's what you don't want that comes to you.

Columbus is a piker beside the man who discovers himself.

Has the Journal met with your approval? If so, help make it better by signing the blank below.

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We request short papers and reports of cases from Iowa Doctors. All papers should be typewritten. Reprints furnished at cost and should be ordered when paper is sent us, as it saves expense.

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OUR PLATFORM.

The Improvement of the Health of Iowa People.
The Improvement in Hygienic Conditions in all Iowa Cities.
The Improvement of the Profession, Individually and Collectively, in the Art and Science of Medicine.
The Improvement in Legislation so as to require High Attainments of every Practician, regardless of his School or Pathy.
The Improvement in Organization, making every legally Registered Physician of Good Standing in his Community a Member of his County and State Society.

Vol. XIX Des Moines, August 15, 1912 No. 2

DRAKE MEDICAL SCHOOL.

We have given over this issue of the Journal to the Drake Medical School.

There are several reasons for this. Drake consolidated with Keokuk Medical School, two years ago, and the interests of two institutions are centered now in Des Moines. The alumni of the two institutions are deeply interested in the welfare of the school, and they are patrons of the Journal as well.

The profession of Iowa should know that Drake is abreast the times in medical instruction, and that Iowa affords excellent opportunities for its young men interested in the study of medicine, both in laboratory and clinical work.

The people and members of the profession in Des Moines are proud of the institution, as evidenced by the $500,000.00 raised last year to hold and maintain the medical department in Des Moines.

There has never been a time in the west when the faculty of a medical college has centered its energies as has the faculty of Drake.

The result can be seen in the results of the examinations before the State Board, where not a graduate has failed since the requirements of the A. M. A. have been met by the medical department.

The facilities for clinical work is illustrated in the two days reunion last spring, when 30 surgical and 15 medical cases were offered.

together with 7 eye and ear cases, in the clinics at Mercy and Methodist Hospitals. At the same time in the dispensary department, 129 cases were cared for.

Laboratories of Drake Medical School.

To the men who graduated four years ago and earlier, the development of the laboratories at Drake will be a revelation of recent educational development.

The laboratory for the study of bacteriology and embryology has working desks for 60 students, fully equipped with water, gas and electric light, microscopes and every necessary device. The room is probably 30 by 60 feet, and has fine window space on the east and south.

The preparation room, under the control of Prof. Begg, is as large as the laboratory for this department was 10 years ago, and is equipped with the latest and most up-to-date devices for preparing the work for the student. It has the preparation ovens, incubators, serum ovens, sterilizers etc.

In another room is the micro-photographic apparatus, projectoscope and other mechanical devices for the enlarging of microscopical sections, to aid the student in microcsopic study.

The development room of this department is particularly interesting, in that no device is absent that is needed in the advanced study of microcsopic reproductive work.

The pathological laboratory accommodates 60 students at a time, and is under the direct control of Prof. D. J. Glomset.

The material is unlimited, and the museum, combination of Keokuk and Drake, contains many rare and interesting collections.

A separate laboratory is devoted to the examination of city water, and daily, advanced students report on the potable condition of our most necessary commodity.

This and the laboratory of physiological chemistry is under the control of Dr. F. J. Smith, the latter accommodating 32 students at a time. In the development of this laboratory, Dr. Smith has utilized his vast knowledge, gained in twenty-five years of laboratory work, and has equipped it with the most useful and scientific paraphernalia that can be used with benefit to the student.

The laboratory for the study of physiology furnishes 40 working desks and the equipment is unusually fine and complete. Dr. Mendenhall, in charge, has brought to Drake the finest and latest devices for the study of this most interesting branch. The laboratory is equipped also, with an operating room, and a bath room where the dogs are prepared for demonstration.

A most interesting and complete department is that under Dr. Lier—the X-ray laboratory.

The oldest and probably the most used is the anatomical laboratory. Here Dr. Lineback has some most interesting dissections and in adjoining room an abundance of supplies for his department.

We would feel that a most interesting and important feature of the Drake school was missed if we did not mention the out patient or dispensary department. (16,968 treatments were given last year.)

Almost the entire first floor is devoted to examination and treatment rooms.

Many minor surgical operations are done here in all branches. An aseptic operating room with a complete sterilizing outfit, and a ward with five beds add much to the students opportunities.

An interesting feature of this dispensary, is the large and serviceable rooms used by the department of eye, ear, nose and throat. The refraction room has complete equipment, while the treatment rooms for eye and throat diseases are not lacking.

Two nurses, one from each hospital, are in attendance daily, and find this work the most interesting part of their training.

Baby Health Contest.

Marshall County will try an inovation at their fair on September 9-13.

One of the Divisions of the Fair will be the Public Health Division and under that, three prizes will be given for the healthiest babies.

Human Health will be the feature for both grown-ups and infants.

Public Health talks will be given by prominent members of the profession and a Health Exhibit of the A. M. A. will be shown.

A Baby Beauty Show will also be held during the Fair and the Prize Baby will head the procession on the last day.

A similar plan of encouraging health in children will be carried out at the State Fair.

Iowa is the first state to start the plan of encouraging the people to greater health endeavor.

Early Diagnosis in Typhoid.

The statement is made in an editorial of the Journal of the American Medical Association, under date of June 29, 1912, pp 2,035 that *"Thus far the ophthalmic reaction gives promise of being the earliest available diagnostic reaction in typhoid."*

If we take into consideration the conditions as they confront us at the present time in which typhoid prophylaxis is coming into use extensively in general practice, it seems to me that the diagnostic value of the ophthalmic reaction is of less value than the leucocytic picture, for

the reason that the ophthalmic reaction undoubtedly is due to the action of toxic substances liberated from the infecting agent (substance injected) upon specific anti-bodies—bacteriolysins, agglutinins, etc. etc.

Individuals previously affected with or immunized against typhoid fever have these specific antibodies present in their blood fluids indefinitely ready at all times to act upon the typhoid bacteria and produce a reaction should they gain entrance into the system, either through the gastro-intestinal tract, or in the form of a vaccine, through the conjunctival membrane.

The typical blood picture, i. e., leucopenia with a decrease of polynuclear cells and an increase of the mono-nuclear elements does not follow artificial immunization by means of typhoid vaccine given prophylactically.

It seems but rational that if the blood-making organs—lymphadenoid tissues—are the channels of entrance of the typhoid bacilli into the body, and constant changes in the structure follow such entrance that it seems but reasonable to infer that in these structures we should seek the *earliest evidences* of the disease.

H. N. B.

The Use of the Sphygmomanometer.

Insurance companies throughout the country are recognizing the value of the use of this instrument in detecting arteriosclerosis and kidney disease.

Among the western companies to order its use is the Cedar Rapids Life Company, whose Medical Director is Dr. Geo. E. Crawford.

The request for its use is as follows:

Where the age is 40 or over, and the insurance.....$3,000.00
Where the age is 45 or over, and the insurance..... 2,000.00
Where the age is 50 or over, in all cases.

We believe this to be a good move, and have no doubt the companies will be benefited by the use of this late scientific device.

BOOK REVIEWS.

INFANT FEEDING.

By CLIFFORD G. GRULES, A. M., M. D., Assistant Professor of Pediatrics at Rush Medical College. Attending Physician to Cook County Hospital. Octavo of 295 pages, illustrated. Cloth $3.00, net. W. B. Saunders Company, publishers, Philadelphia.

The author outlines very comprehensively, the plan of milk mixture for artificially fed infants, and along this line reasons scientifically, and with his experience can justify his plan.

This work is well written and covers much detail regarding the care of the infant.

THE PITUITARY BODY AND ITS DISORDERS.

Clinical State Produced by Disorders of the Hypophysis Cerebri, by HARVEY CUSHING, M. D., Associate Professor of Sur-

gery, the John Hopkins University, Professor of Surgery (Elect.), Harvard University. An amplification of the Harvey Lecture for December, 1910, with 319 illustrations. Price, $4.00, net. J. B. Lippincott Company, publishers.

This work is an extensive resume of scientific knowledge, pertaining to the physiology, pathology and symptomatology of the pituitary body, paying special attention to Acromegaly and Frohlichs syndrome. An especially interesting group of cases is given, making the work a very important monograph.

AN ESSAY ON HASHEESH

Including observations and experiments, by VICTOR ROBINSON, author of "Pathfinders in America." Price $.50, net. Medical Review of Reviews, New York, publishers.

An interesting description of the effect of Cannabis Indica Intoxication.

PHARMACOLOGY AND THERAPEUTICS

By HORATIO C. WOOD, Jr., M. D., Professor of Pharmocology and Therapeutics in the Medico-Chirurgical College; Physician to the Medico-Chirurgical Hospital; Second Vice-Chairman of the Committee of Revision of the U. S. Pharmacopoeia. Price, $4.00, net. J. B. Lippincott Company, publishers.

The remarkable change in the study of pharmacology in the last decade has settled itself into the known changes produced by drugs, and knowledge of what drugs do.

The compiling of facts about drugs made the study imperative, whereas, now, the actual working of drugs is demonstrated in a scientific way that makes the subject a study rather than a memory process.

In this work, the more common drugs are enumerated, and their actions fully explained.

The work is an interesting study now, and is made to conform with the development of the scientific study.

ARTERIOSCLEROSIS.

Etiology, pathology, diagnosis, prognosis, prophylaxis, and treatment, with a special chapter on blood pressure. By LOUIS M. WARFIELD, A. B., M. D., Assistant superintendent and resident physician to Milwaukee Hospital; Assistant Professor of Medicine, Wisconsin College of Physicians and Surgeons, Milwaukee, Wis., etc. With an introduction by W. S. THAYER, M. D., Professor of Clinical Medicine, John Hopkins University. Illustrated with 28 illustrations. Price $2.50, net. C. V. Mosby Company, publishers.

The author has entered into the diagnosis very carefully and discusses the etiologic causes with unusual clearness and freedom.

The diagnosis, prognosis and treatment are discussed in a manner that convinces the reader of the author's ability.

COLLECTED PAPERS BY THE STAFF OF ST. MARY'S HOSPITAL.

(Mayo Clinic) for 1911. Octavo of 603 pages, illustrated, Philadelphia and London; W. B. Saunders Company 1912. Cloth, $5.50 net.

The surgeons of the world will greet with pleasure, the appearance of this compilation of papers.

The Mayos and the members of their staff reproduce here the combined results of their investigations in a most pleasing and satisfying way.

The vast amount of material and the careful manner in which it is worked out by the staff, marks the papers herein as exceptional.

The ambitious surgeon will find satisfaction in reading, and the other kind may be helped to better endeavor by giving the work his careful attention.

Such works are post-graduate in the highest sense of the term.

SURGICAL AFTER-TREATMENT.

By L. R. G. CRANDON, M. D., Assistant in Surgery at Harvard Medical School, and Albert Ehrenfried, M. D., Assistant in Anatomy at Harvard Medical School. Second Edition, practically rewritten. Octavo of 831 pages, with 264 original illustrations. Cloth, $6.00 net; half Morocco, $7.50 net. W. B. Saunders Company, Philadelphia, publishers.

The importance of works of this kind has been recognized only a few years. It was thought that anyone capable of doing surgery could not fail on after-treatment, but surgery has advanced to that point where operations are now done that ten years ago would have been overlooked or passed for want of assurance that the operation would furnish the relief needed.

And perhaps the lack of after-treatment may have necessitated subsequent operations.

At any rate this work has gone elaborately in to the matter of after care, and refers to almost every condition met by the surgeon.

PELLAGRA.

By STEWART R. ROBERTS, S. M., M. D., Associate professor of the principles and practice of medicine, Atlanta, College of Physicians and Surgeons, Atlanta, Georgia; Physician to the Wesley Memorial Hospital; Formerly Professor of Biology in Emory College. With 89 special engravings and frontispiece. Price $2.50, net. C. V. Mosby Company, St. Louis, publishers.

So much has been written on this subject in the last two years, that it gives one a sense of pleasure to find a work devoted to the subject.

Much historical reference is given in the work that will be enjoyed by the medical man, and the symptomatology and diagnosis will be appreciated.

The book is well illustrated. An unusual amount of time and energy has been given to the compiling of the work, and because of its completeness, it will stand as a classic for years.

MEDICAL NEWS NOTES.

Dr. A. B. Bowen of Maquoketa, has returned from his trip abroad.

Dr. J. S. Stevens of Waterloo, is enjoying a month's visit in the west.

Dr. J. E. O'Keefe of Waterloo, has returned from a vacation spent in the east.

Dr. W. W. Gingles of Castana, had a very severe attack of appendicitis in July.

Dr. and Mrs. J. E. Garver of Sioux City, spent a vacation at Spirit Lake in July.

Dr. and Mrs. A. R. Amos of Des Moines, spent part of July in northern Minnesota.

Dr. M. J. Lynch of Templeton, is taking post graduate work in obstetrics, in Omaha.

Dr. L. T. Reed and family of Gravity, visited in Kansas, in July, with Mrs. Reed's sister.

Dr. L. J. Van Gorden of Emmetsburg, has recently suffered a severe attack of tonsilitis.

Dr. W. H. Seymour and family of Charles City, have been enjoying an outing at Clear Lake.

Dr. and Mrs. S. T. Stevens of Mt. Pleasant, enjoyed a two weeks outing at Spirit Lake, in July.

Dr. C. B. Taylor and family of What Cheer, enjoyed a two weeks vacation in July at Clear Lake.

Dr. and Mrs. H. C. Moffett of Clinton, are spending a couple of months touring the western coast.

Dr. and Mrs. W. E. Owen of Cedar Rapids, have returned from their vacation spent in Wisconsin.

Dr. A. W. Elmer and family of Davenport, spent July at their summer cottage in Bay View, Michigan.

A twenty-five room hospital with two wards is to be established in Ottumwa by the Sisters of Humility.

Dr. and Mrs. J. H. Lawrence of Sioux City, are taking a trip through the western states and along the coast.

Dr. G. Hardy Clark and Dr. Margaret V. Clark of Waterloo, have recently returned from their extensive tour of Europe.

Dr. and Mrs. J. W. Davis of Lansing, enjoyed a vacation in July at the home of Mrs. Davis' mother in Minnesota.

Dr. Lester Royal of Iowa City, was badly burned, the latter part of July, by the explosion of an oil stove in his office.

Cleve Welsh, the young daughter of Dr. Fred Welsh of Boone, is recovering from her very severe siege of typhoid fever.

Dr. D. F. Fitzpatrick of Iowa City, has returned from his visit in the east, and is enjoying better health than he has for months.

Dr. and Mrs. M. W. White of Sioux City, are enjoying an extensive trip through Yellowstone Park and along the Pacific Coast.

Dr. and Mrs. F. Lambach of Davenport, have recently returned from a trip through Yellowstone Park and to other points in the west.

Dr. and Mrs. W. E. Alton of Fort Dodge, have returned from their seven weeks trip in their boat on the Mississippi and Ohio rivers.

Dr. J. E. Conn of Ida Grove is now sole owner of the hospital at that place, having purchased the interest of his brother.

Dr. B. J. Dyer of Ames, who is taking post graduate work in New York reports very satisfactory work along the line he is studying—eye and ear.

Dr. A. G. Field of Des Moines, was dangerously sick from an attack of stomach hemorrhage, last month and his friends fear for his recovery.

Dr. W. E. Long sustained a broken shoulder, in July, when the horse that he was driving became frightened and ran away, throwing the doctor to the pavement.